NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

Congressional Information Service, Inc
Washington, D.C.
CIS

S. Hrg. 98-839

CAPITAL FINANCING UNDER MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

MARCH 9, 1984

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
35-893 O WASHINGTON : 1984

S361-43

COMMITTEE ON FINANCE

ROBERT J. DOLE, Kansas, *Chairman*

BOB PACKWOOD, Oregon
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado
STEVEN D. SYMMS, Idaho
CHARLES E. GRASSLEY, Iowa

RUSSELL B. LONG, Louisiana
LLOYD BENTSEN, Texas
SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas

RODERICK A. DEARMENT, *Chief Counsel and Staff Director*
MICHAEL STERN, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

DAVID DURENBERGER, Minnesota, *Chairman*

ROBERT J. DOLE, Kansas
BOB PACKWOOD, Oregon
JOHN HEINZ, Pennsylvania

MAX BAUCUS, Montana
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine

CONTENTS

ADMINISTRATION WITNESS

Page
Streimer, Robert A., Acting Deputy Director, Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administration 17

PUBLIC WITNESSES

American Health Care Association, Gary Capistrant, Director of Congressional Relations and Public Policy 162
American Hospital Association, Jack W. Owen, executive vice president 41
Associated Health Systems, Merlin Duval, M.D., president 98
Bromberg, Michael D., executive director, Federation of American Hospitals, Washington, DC 80
Butler, Gordon H., administrator, Memorial Community Hospital, Jefferson City, MO 50
Capistrant, Gary, director of congressional relations and public policy, American Health Care Association 160
Catholic Health Association of the United States, John E. Curley, Jr., president 55
Curley, John E. Jr., president, Catholic Health Association of the United States 55
DuVal, Merlin, M.D., president, Associated Health Systems, Phoenix, AZ 98
Federation of American Hospitals, M. Keith Weikel, Ph.D., vice chairman of the board 80
Georgetown University Hospital, Washington, DC, Charles O'Brian, administrator 53
Healthcare Financial Management Association, Ronald R. Kovener, vice president 73
Holy Cross Health System, Sister Geraldine Hoyler, vice president for finance.. 69
Hoyler, Geraldine, Sr., vice president for finance, the Holy Cross Health System, South Bend, IN 69
Intermountain Health Care, William Nelson, vice president for finance 101
Kovener, Ronald R., vice president, Healthcare Financial Management Association 73
Memorial Community Hospital, Jefferson City, MO., Gordon H. Butler, administrator 50
Nelson, William, vice president for finance, Intermountain Health Care, Salt Lake City, UT 101
O'Brian, Charles, administrator, Georgetown University Hospital, Washington, DC 53
Owen, Jack W., executive vice president, American Hospital Association 41
Santa Clara County Valley Medical Center, Robert Sillen, administrator 102
Sillen, Robert, administrator, Santa Clara County Valley Medical Center, San Jose, CA 102
Weikel, M. Keith, Ph.D., vice chairman of the board, Federation of American Hospitals 81

ADDITIONAL INFORMATION

Committee press release 1
Chart No. 1, Medicare Inpatient Capital Expenditures 21
Chart No. 2, Community Hospitals: Distribution by Ratio of Capital to Operating Costs 22

Page
Prepared statement of Robert A. Streimer 24
Chart No. 3, Hospital Characteristics Associated with Lower and Higher Ratios of Capital to Operating Costs 36
Prepared statement of the American Hospital Association 42
Prepared statement of the Memorial Community Hospital 51
Prepared statement of the Catholic Health Association 57
Prepared statement of the Healthcare Financial Management Association 74
Prepared statement of the Federation of American Hospitals 83
Prepared statement of the Santa Clara County Valley Medical Center 106
Prepared statement of the American Health Care Association 162

COMMUNICATIONS

University of Michigan Hospitals 177
University of Minnesota Hospital and Clinics 192

CAPITAL FINANCING UNDER MEDICARE PROGRAM

FRIDAY, MARCH 9, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:11 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing and a document prepared by the committee staff follow:]

[Press release from the U.S. Senate, Subcommittee on Health, Committee on Finance, Feb. 13, 1984]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON CAPITAL FINANCING UNDER MEDICARE PROGRAM

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the dynamics of capital financing under the medicare program's existing provisions for reasonable cost reimbursement. The hearing is the first in a series on capital financing.

The hearing will be held on Friday, March 9, 1984, beginning at 10:00 a.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Durenberger noted that "for years the medicare program has reimbursed hospitals for their capital costs on a reasonable cost basis. Under the provisions of the Social Security Amendments of 1983, however, that will cease to be the case beginning October 1, 1986. In adopting a prospective payment system for hospitals under medicare program, the Congress let it be known that some basis other than reasonable cost would be adopted to pay for capital. Whether and how the current prospective rate system can be modified to cover capital as well as operating costs are decisions that have yet to be made. Before we can make those decisions, however, we need as complete an understanding as possible of the current capital financing process and how various factors impinge on that process."

Senator Durenberger stated that the Subcommittee is interested in hearing from the principals involved in capital financing. This includes, but is not limited to, individuals and organizations actively engaged in debt and equity placement, bond rating, feasibility studies, ownership restructuring, and hospital management and ownership. The Subcommittee is particularly interested in understanding the roles played by the principals, the factors which they consider, and how those factors influence their decisions. Because the Subcommittee plans to hold other hearings on new methods to deal with capital costs, Senator Durenberger urged witnesses to focus their testimony on providing an understanding of the present process rather than the pros and cons of proposals for future capital payment.

HOSPITAL CAPITAL COST REIMBURSEMENT UNDER THE MEDICARE PROGRAM

Prepared by the Staff for the Use of the
Committee on Finance
United States Senate

March 1984

INTRODUCTION

From 1966 until October 1983, payments for hospital services under the Medicare program were made on the basis of certain allowed or "reasonable costs" actually incurred by participating hospitals in providing care to beneficiaries. In 1983, however, Congress adopted a new system for paying hospitals on the basis of prospectively determined specific amounts on a per case basis, according to individual patient diagnoses. 1/ The purpose of the changes in reimbursement policy was to create incentives for hospitals to improve controls over spending and resource use in serving Medicare hospital inpatients.

Not all of the expenses previously reimbursed by Medicare on a reasonable cost basis, however, were incorporated into the prospective payment scheme. Present law provides that certain capital-related costs be excluded from the prospective payment system until October 1, 1986. Until then, these capital costs will continue to be reimbursed on a reasonable cost basis. Congress has directed the Secretary of Health and Human Services (HHS) to study and report to Congress (by October 20, 1984) on methods and proposals for including capital-related costs in the prospective payment system.

1/ P.L. 98-21, the Social Security Amendments of 1983. For a discussion of the elements of Medicare's prospective payment system, see CRS Issue Brief IB83171, "Prospective Payments for Medicare Inpatient Hospital Services."

I. BACKGROUND

It is the purpose of this paper to review present payment policies under Medicare for capital-related costs. Options for including those costs in the program's prospective payment system will be reviewed at a later time.

A. What Are "Capital Related Costs?"

In today's business world the word "capital" has a variety of meanings, not all of which are applicable to a discussion of Medicare's reimbursement policies. For example, in some circumstances, capital is synonymous with the term "total tangible assets." In this sense, the capital of a hospital is equal to the total value of all its physical assets--items of value owned by the enterprise. For Medicare's purposes, however, this meaning is too broad.

Capital, as it relates to the Medicare program, is best defined in terms of the capital-related costs for which a hospital will be reimbursed. Under the Medicare program, capital-related costs include depreciation, leases and rentals for the use of depreciable assets, insurance expense on depreciable assets, interest expense incurred in acquiring land and depreciable assets, and taxes on land or depreciable assets. For proprietary providers, a return on equity capital is also a reimbursable capital-related cost.

With the exception of return on equity capital, capital-related costs are the direct result of acquiring assets of a relatively permanent nature, held for continuous operation of the hospital and not intended for conversion into cash or to be consumed in a single year. Such capital assets include land, plant, and equipment. The funds needed to acquire such land, plant, or equipment; or to renovate, expand or replace existing plant and equipment represent a hospital's "capital needs."

B. Financing Hospital Capital Needs--Brief History

In most economic enterprises, capital needs are met through debt financing, equity financing or retained earnings. For hospitals, however, philanthropy and government subsidy have also been important to meeting capital needs.

Hospitals have not ordinarily been able to generate the retained earnings necessary to finance their capital needs. Instead, financing for capital purposes has usually come from other sources. For example, until World War II, the major source of hospital capital financing was philanthropy--e.g., donated funds from individuals, religious groups or local community subscription. 2/ After the War, public financing in the form of Federal grants and loans under the Hill-Burton program became an increasingly important additional source of capital financing for hospital plant construction and renovation for many institutions. 3/

The end of the War also marked the beginning of dramatic growth in private health insurance protection, provided through the workplace, against the costs of hospital care for workers and their dependents. This development was important in the history of capital financing in the hospital sector, because the

---

2/ It has been estimated that about two-thirds of capital provided the industry before the War came from philanthropic sources.

3/ Nearly 4,000 hospitals received about $4 billion in grants, while 300 facilities received an additional $1.9 billion in loans and loan guarantees, under the Hill-Burton program before it ceased to exist as a source of capital in the 1970's.

certainty of payments from such sources helped to improve the financial stability of many community hospitals. Such payments made possible the accumulation of internally generated funds (retained earnings) to meet capital needs and also increased the stability of hospitals' cash flow. Improved cash flow stability in terms of anticipated future revenues to repay borrowed principal and meet interest obligations enhanced opportunities to use borrowed funds (i.e., debt capital) as a source to finance capital needs.

The enactment of Medicare and Medicaid in the mid-1960's also had major effects on the relative importance of different sources of hospital capital financing. First, as with private insurance coverage, Medicare and Medicaid further improved the general financial stability of the hospital industry. The elderly and the poor--both important segments of the caseloads of many community hospitals--were, before creation of these two governmental programs, often unable to pay for the hospital services they received. Medicare and Medicaid helped to reduce both the free care and bad debt burdens represented by each of these groups for many institutions.

Second, Congress decided to pay for care provided to the aged and poor under these new programs on the basis of the actual costs incurred, not on the basis of the prices charged by the hospitals for such services. This decision to opt for cost-based reimbursement further encouraged borrowing as a source of capital financing because the Government included in its definition of reimbursable costs, payments for depreciation and interest expense on borrowed funds. 4/

Lenders were encouraged to make funds available to hospitals because the certainty of payment of depreciation and interest significantly reduced the

---

4/ These and the other capital-related expenses paid for on a cost basis under Medicare are discussed in detail in the next section of this report.

risk that borrowed funds would not be repaid. Debt financing was also encouraged because cost reimbursement precludes a hospital from accumulating earnings from a cost-based payer, since efforts to reduce spending are met by equal reductions in revenues. Reimbursement of depreciation expense also made borrowing an attractive method of financing capital needs. In the early years of debt repayment, cash inflow for depreciation often exceeds cash outflow for principal repayment (amortization), thereby generating "excess" funds that can be used for any number of noncapital-related purposes. 5/

Other factors, of course, also contributed to the steadily increasing use of debt as the principal source of funds to meet capital needs for the hospital industry during the last two decades. These included mortgage loan insurance to facilitate hospital plant and equipment purchases, governmental policies that expanded and encouraged the issuance and use of tax-exempt debt instruments to finance capital needs, and long periods of persistent and sometimes severe inflation. For example, hospitals often found that loans could be paid back in the future with dollars cheaper than those which had been borrowed. The impact of these influences on the sources of capital financing has been dramatic. One estimate for 1962 indicated that about only 12 percent of new hospital plant was financed by borrowing. 6/ By 1969, about 40 percent of the construction costs of nonprofit hospitals and more than 60 percent for investor-owned

---

5/ Amortization is the repayment of loan principal on an installment basis. Under a level loan repayment schedule, the amount of the installment payment representing principal is, at the beginning of an amortization period, usually quite small and usually less than the depreciation amounts reimbursed by Medicare during the initial years of repayment of the loan.

6/ J.B. Silvers, "How Do Limits to Debt Financing Affect Your Hospital's Financial Status?" Hospital Financial Management, February 1975, p. 32.

institutions were financed from debt sources. 7/ Debt is now by far the most important source of capital financing for the hospital industry: 8/

Sources of Hospital Construction Funding, 1973-1981

Funding Sources	1973	1977	1981
Government grants & appropriations	20.8%	17.2%	12.1%
Philanthropy	9.9	7.1	3.9
Hospital reserves a/	14.9	13.2	14.9
Debt............................	54.4	62.5	69.1

a/ Reserves include funded depreciation, sale of replaced assets and equity for investor-owned hospitals.

7/ Irwin Wolkstein, "The Impact of Legislation on Capital Development for Health Facilities," Health Care Capital: Competition and Control. Ballinger Publishing Company, Cambridge, Massachusetts, 1978.

8/ Survey of Sources for Hospital Construction, American Hospital Association. The hospital industry borrows funds for more than construction. For example, about 60-65 percent of the debt-raised capital in 1981 went for project costs, including construction expenses, equipment acquisitions and architectural and engineering fees. The balance of the borrowings was used to refinance existing debt, for debt service reserves and capitalization of interest funds, and for other purposes.

II. MEDICARE'S PRESENT CAPITAL PAYMENT RULES

A. General

Present law provides that certain capital-related costs are reimbursable on a reasonable cost basis and are excluded from Medicare's prospective payment system for hospital services until October 1, 1986.

Current regulations define the capital-related costs that the Secretary of Health and Human Services recognizes as allowable for reimbursement purposes. Such costs must be reasonable and related to the provision of patient care. Reasonable costs include all necessary and proper expenses incurred in rendering services to beneficiaries. To be allowed, costs cannot exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Under Medicare, the capital costs of participating hospitals are apportioned or divided between Medicare program beneficiaries and the other patients using the facilities. This is accomplished through accounting methods which measure the use of hospital resources by Medicare beneficiaries relative to the total hospital resources used by all patients served. Once Medicare's share is determined, such amounts are paid to the facilities in addition to any payments for inpatient hospital services under the prospective payment system and for medical education.

B. Major Elements of Capital Cost Reimbursed by Medicare

Among the major elements of capital cost currently reimbursable under Medicare are: 9/

1. Depreciation. Medicare recognizes depreciation as an element of capital cost payable by the program. Depreciation expenses are amounts which represent the portion of an asset's cost that is charged-off to a particular period of operation, such as an accounting or reporting period (usually a year). In the case of hospitals, depreciable assets include: buildings, building equipment, major movable equipment, minor equipment, land improvements and leasehold improvements made by a lessee. 10/

Depreciation accounting is a system of accounting which prorates the acquisition cost or other basic value of tangible assets, less salvage value (if any), over the "useful lives" of such assets. 11/ The measurement of periodic depreciation expenses or charges is dependent on three factors: the depreciation base, the "useful life" of the asset and the depreciation method.

Under Medicare, depreciation is based upon the "historical cost" of the acquired assets. Historical cost is the cost incurred by the present owner in acquiring the assets. The estimated useful life of an asset is its expected useful life to the hospital, not necessarily the asset's inherent useful life or physical life. In general, the estimated useful lives developed by the American Hospital Association (AHA) are used by hospitals and accepted by the

---

9/ In addition, the regulations define capital-related costs to include a number of other minor items, such as certain betterments and improvements, the costs of minor equipment that are capitalized rather than charged off to expense, some insurance costs of depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

10/ Land is not a depreciable asset.

11/ Salvage value is the estimated amount expected to be realized upon sale or other disposition of a depreciable asset at the end of its useful life.

Medicare program for determining depreciation. 12/ For assets acquired in 1983 and thereafter, use is made of the AHA's Estimated Useful Lives of Depreciable Hospital Assets (1983 edition) as a guide for such purposes. An earlier (1978) edition was used for assets acquired in 1982. The AHA's 1973 Chart of Accounts is used in connection with assets acquired before 1982.

Since August 1, 1970, proration of the historical cost of an asset under Medicare is generally allowed only on a "straight-line" basis. Under this method, the historical cost of an asset (minus any salvage value) is recovered by (and, in the case of Medicare, paid to) the hospital in equal amounts over the useful life of the asset. Medicare does not require the funding of depreciation; that is, the hospital is not required to set aside cash (in an amount equal to allowed depreciation) for the replacement of depreciated assets, buildings or equipment.

The Economic Recovery Tax Act of 1981 (P.L. 97-34) made a number of changes in the calculation of depreciation for income tax purposes. However, the law excludes Medicare (and other programs administered by the Secretary of Health and Human Services) from the new depreciation rules for purposes of determining cost reimbursement under the program.

2. Interest Expense. Necessary and proper interest expense on current and capital indebtedness is included as an allowable cost under Medicare. Capital indebtedness represents long-term loans in which the funds are used for meeting capital needs, i.e. acquiring or improving facilities and equipment.

To be recognized as a Medicare allowable cost, interest must be incurred on funds borrowed to satisfy the financial needs of a hospital and must be for a

---

12/ For example, the AHA guidelines show a useful life of no more than 40 years for buildings. Fixed assets in the buildings, such as elevators, heating and air conditioning, plumbing, etc, have suggested useful lives of between 10 and 20 years.

purpose reasonably related to patient care. The rate of interest must not exceed what a prudent borrower would have had to pay in the money market in an arms-length transaction. The interest must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization.

Generally, allowable interest expenses are reduced by investment income, except where such income is from: gifts, grants, endowments, funded depreciation, pension funds, and deferred compensation funds.

3. Return on Equity Capital of Proprietary Hospitals. A specified return on equity (or owner) capital invested and used in providing patient care is an allowable cost for proprietary, or for-profit, hospitals under Medicare. Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the net investment in plant, property and equipment (net of accumulated depreciation and long term debt) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The base amount of equity capital used in computing the allowable return is the average investment of the owners during a reporting period. Under current law (P.L. 98-21) the rate of return is equal to the rate of interest paid by the Federal Treasury on the assets of Medicare Hospital Insurance Trust Fund. Prior to May 1983, the rate of return was one and one-half times the interest paid on trust fund assets:

Interest Rates on Medicare Hospital Insurance Trust
Fund Assets and Rate of Return on Equity Capital

For the Month of:	Interest rate HI Trust Fund*	Payment Factor	Rate of Return on Equity Capital*
July 1982	13.875	x 1.5	20.812
October 1982	11.625	x 1.5	17.438
January 1983	10.500	x 1.5	15.750
April 1983	10.625	x 1.5	15.938
July 1983	10.875	x 1.0	10.875
October 1983	11.375	x 1.0	11.375

* Annualized rate

C. Capital-Related Costs As a Part of Total Costs

In adopting a prospective payment system for hospitals under Medicare, Congress sought to establish effective financial incentives (including both rewards and penalties) to control spending in the provision of inpatient services to beneficiaries. Although Congress excluded medical education and capital-related costs from the prospective payment system, most of the operating costs associated with inpatient treatment are now incorporated into the prospective rates. In fiscal year 1984, inpatient operating costs are expected to total 39.2 billion. It is estimated that hospital capital-related costs in FY 1984 will be about $2.9 billion; $1.6 billion (55 percent) for depreciation of fixed assets, $0.4 billion (14 percent) for depreciation of moveable assets, $0.7 billion (24 percent) for interest costs and $0.2 billion (7 percent) for return on equity.

Reimbursable capital-related costs, therefore, represent only a relatively small proportion of total Medicare hospital spending already subject to prospective payment--about 7.4 percent of operating costs. However, it is also important to note that, while capital-related costs are now reimbursed separately from the prospective system, operating and capital decisions made by hospital managers are almost always interrelated with one another. As a result, many capital decisions now made by hospitals--particularly those relating to moveable equipment--are already being influenced to some extent by Medicare's prospective payment incentives.

Nevertheless, capital payment policies under prospective payment have become a topic of considerable discussion and debate, despite the relatively small percentage of funds actually expended by Medicare for such purposes. The reasons for this interest are many and varied. First, although total reimbursable capital-related costs under Medicare represent on average only about 6.6 percent of total (rather than operating) hospital costs, many hospitals have a much greater than average proportion of capital-related costs in some years, while others have a lower than average proportion of capital-related costs. Capital costs, in other words, are unevenly distributed among the hospitals participating in the program. This is largely due to the fact that major capital expenditures--especially for replacing, modernizing or adding new buildings and fixed equipment--occur infrequently. Hospitals that have just begun or completed large capital projects may, in any one year, have capital costs amounting to well over 20 percent of their total expenses. Older facilities, on the other hand, can have capital costs amounting to 4 percent or less of their current total expenses: 13/

13/ Gerard Anderson, from a presentation to the Advisory Committee on Social Security; reprinted in "Including Capital in Prospective Payment: Questions and Information Pertinent Thereto," Catholic Hospital Association, October 1983. Data excludes return on equity amounts.

Medicare Capital Costs, As Percentage of Total Hospital Costs, 1981

Capital costs/Total costs	Percentage of Hospitals
Less than 4%	25.3%
4% to 6.6%	34.6
6.6% to 10%	22.2
10% to %15	12.6
15% to 20%	3.5
More than 20%	1.9
Mean percentage (all hospitals)	6.6%

D. Future Payment of Capital-Related Costs

Public Law 98-21, the Social Security Amendments of 1983, directs the Secretary of Health and Human Services to study and report to Congress on methods and proposals under which capital-related costs, including a return on equity, may be included in the prospective payment system.

P.L. 98-21 also provides that, if legislation is not enacted by Congress prior to October 1, 1986, regarding inclusion of capital-related costs under the prospective payment system, Medicare payment cannot be made for capital costs unless a State has a capital expenditure review agreement with the Secretary of HHS (under Sec. 1122 of the Social Security Act) and the State has recommended approval of the expenditure. The conference report on P.L. 98-21 also expresses the intent of Congress that, if the Secretary has implemented a system of prospective payments for capital-related costs (without any further action by Congress) and the mandatory Section 1122 approval process goes into effect, the Secretary must make adjustments to the payment rates to reflect capital-related costs not approved under Section 1122.

P.L. 98-21 also includes a provision expressing the intent of Congress that, when including capital-related costs under the prospective payment system, new capital projects for which expenditures are made on or after the effective date of the implementation of the prospective system may be reimbursed differently from projects begun before that date. In other words, no assurances are given that obligations incurred after such date will be reimbursable on a reasonable cost basis.

Uncertainty about future payment policy regarding capital-related costs is cause for concern on the part of hospitals that have recently begun or completed large capital projects, hospitals that anticipate undertaking such projects in the near future, and the financial institutions involved in financing hospital capital projects. Until a decision is reached as to whether and how capital-related costs are incorporated into the current prospective payment system, the uncertainty will continue. In order to reach that decision, the Subcommittee on Health of the Senate Committee on Finance plans to hold hearings to obtain an understanding of the capital financing process and the factors that affect that process. The Subcommittee will then examine the various proposals for the future payment of hospital capital-related costs under Medicare.

Senator **Durenberger**. The hearing will come to order.

I had the good fortune, which I don't always have, to be able to read the statements of all the witnesses last evening during my normal 3-hour commute from the Capitol to McLean. [Laughter.]

And I want to share with you a couple of impressions—several impressions as a matter of fact. First, as I read through the statements of the hospital witnesses, the commitment—that is impressive—of American hospitals to changing the way Americans secure themselves against the economic consequences of illness.

Second, the special cooperative spirit of American hospitals with all the rest of us who are involved in the process of change.

Third, the unique role that capital investment—especially in fixed assets—will play in the management decisions that are necessary to facilitate this change in our sick care protection system.

Fourth, the unanimity—practical unanimity—of opinion that this Senator's judgment was correct last year in conference on the Social Security Reform Act that getting a prospective payment system in place with a national average and a realistic grouping of diagnoses as quickly as possible for hospital operating expenses was much more significant to system change than doing the same thing for capital, at the same time. I may be entitled to the opinion that an appendectomy should cost no more in Detroit than in Westover Shoe, MN, but I am not necessarily entitled to arrive at the same conclusion about the reimbursement value of each square foot of each of America's 7,000 plus hospitals. Of greater importance to the people of this country—from the view of institutional providers of health care in terms of what goes on in this room right here—is not necessarily what we do about incorporating capital factors into prospective payment systems.

What may be of much more substantial importance is what the Senate Finance Committee and on recommendation, I hope, of this subcommittee in some area does over the next 3 years with regard to national policy on prospective payment of vouchers and medicare, deciding the Federal role in providing access to health care to the approximately 30 million economically disadvantaged Americans, deciding the tax and reimbursement treatment for high technology, deciding the Federal role if any in medical education, deciding the income tax treatment for purchase of debt instruments, deciding the income tax treatment for charitable and philanthropic endeavors, deciding the income tax treatment of income to the providers of health care, and deciding income tax treatment of medical expenses and employee fringe benefits. That is not an all-inclusive list necessarily. Those are only the things that occurred to me in the middle of the night last night.

All of this is by way of indicating that today's subcommittee hearing is just one block in a building process for a new high quality and affordable nondiscriminatory health care delivery system in America. I would like to say to the witnesses today, on the subject of capital, that I recognize the legacy that has been visited on the American hospital industry of the Hill-Burton program, the legacy of the post-war golden handcuffs of employer health insurance and many other cost base reimbursement systems, the legacy of inflation and its rewards for profligacy in borrowing, the legacy of low risks for hospital management, the legacy of certificate of need, the legacy of cross subsidies, of services, and the legacy of population shifts around this country. I recognize the problems of rapid change in third-party payment systems. I recognize the need for phasing, and in that regard, your testimony regarding more hospital specificity in the capital area than in operating payments. I recognize that, as we approach the subject, it is much more important for us in policy making roles to put in place reliable signals for the future that would penalize providers for the past.

And I would close by saying that today's witnesses are here because of our confidence in their judgment and in their commitment. I will say that today begins a process that—if all goes well—will come to policy concensus by the end of this calendar year, when we will also have in hand recommendations from the Department of Health and Human Services and from other interested and involved parties as well as from our colleagues on the House side who are much more anxious to deal with this subject than we might on occasion appear to be.

So, with those comments, let me indicate that we won't necessarily be using our light system this morning, which doesn't mean that I have got all day for this subject nor that you do, but that many of the people who are going to testify here today have been here before, and I can assume that your statements will be relatively brief and in summary in nature, and I have a few questions to ask of all of you.

So, the first will be Bob Streimer, who is Acting Deputy Director of the Bureau of Eligibility, Reimbursement and Coverage of the Health Care Financing Administration, Washington.

Bob, we welcome your statement.

STATEMENT OF ROBERT A. STREIMER, ACTING DEPUTY DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. STREIMER. Thank you, Mr. Chairman. I am pleased to be here today to discuss how the medicare program currently reimburses providers for capital costs, and as you mentioned, I think that now is a particularly good time to review our existing practices as in the near future we must decide how to change the capital reimbursement system.

Capital reimbursement expenses are, as you know, excluded from the prospective payment system, and we are continuing to follow the same principles we have for the last 18 years. This is a system of cost reimbursement.

The purpose of cost reimbursement of capital-related expenses is to pay only for the actual costs which are incurred in the delivery of care to medicare beneficiaries. In addition to using generally accepted accounting principles in defining and determining what these costs are, it has been necessary, over the last 18 years, for the medicare program to define additionally what is meant by the various elements of capital costs. These are presented in great length in our numerous manuals and regulations and have been evolving over the past 18 years. The capital costs which medicare recognizes are as follows. We recognize the depreciation of assets, based on the historical cost of the asset which is prorated over the life of the asset. We recognize leases and rentals on assets that would be depreciable if the provider owned them outright.

We recognize the cost of improvements to those assets. We recognize the costs of minor equipment which providers choose to capitalize rather than to expense, which would mean to write them off in the year that they purchased then.

We recognize the necessary and proper interest expense on any loans used to acquire land or depreciable assets that are used for patient care. We recognize the taxes that providers pay on the land and on the depreciable assets that are related to patient care. We recognize any and all insurance expense which is related to those assets used for patient care. And in the case of proprietary providers, we also recognize return on the equity capital that they have invested in their provider operations.

Since the beginning of medicare, there have been a number of modifications in how we have treated capital—both regulatory and legislatively. When the program began on July 1, 1966, all the elements that I just mentioned were included, except for the return on equity capital.

I would like to go through some of the major changes. In November 1966, the medicare statute was amended to add a return on equity capital for proprietary providers. The next major change was in August 1970, and this was a rather significant regulatory change. During the period of 1966 through 1970, there were many program abuses associated with the rapid depreciation and resale of provider investments. In August of 1970, the Bureau of Health Insurance prohibited the use of any accelerated method of depreciation for any assets purchased after August 1, 1970. In addition, the allowance for the return on equity capital was no longer able to be applied to goodwill, and goodwill has been defined by the program as the excess over the asset value that the purchase price represents. In July of 1979, the program for the first time excluded capital from the application of any of the program's cost limits—specifically, at that time, the routine service cost limits. Several times since then, moving up to prospective payment, capital and some other expenses have generally been excluded from various rate setting and cost limit systems.

In August 1983, the program issued instructions noting that the accelerated cost recovery system that was put into effect on January 1, 1981 was not appropriate for use in the medicare program because the accelerated cost recovery system is not a true measure of the useful life of an asset. Therefore, we would not recognize it for medicare purposes.

Prior to the implementation of the prospective payment system, capital expenses were generally treated as overhead within the broad regulatory definitions of medicare covered allowable costs. Under the prospective payment regulations, which were issued in September and then revised just this past January, because the capital costs are paid on a different basis than the inpatient operating costs, it became necessary to spell out in great detail in the regulations specifically which were the capital expenses not covered by the DRG payments.

I would like to spend just a very few minutes touching on each of the major expense categories and what they mean. The depreciation has been limited by the program to the historical cost of the asset over its estimated useful life. Where an ongoing facility is acquired by a purchase or a merger, the historical cost is defined as the least of three different values. It is the least of the purchase price paid by the buyer, the fair market value of the assets, or the current reproduction cost depreciated on a straight-line basis. In establishing the useful life of an asset for any of these three determinations, providers must use reasonable useful life guidelines that have been approved by the Secretary.

As I mentioned earlier, the depreciation expenses that are then ultimately allowed also include depreciation on any improvements and minor equipment. When there is a sale or a merger of a facility, depreciation expenses must be adjusted by the gains or losses that are realized as a result of that transaction. We also recover portions of accelerated depreciation that have been claimed on those assets that were purchased prior to August 1, 1970.

The costs of any leases and rentals are included in capital-related costs, if they relate to assets that are used for patient care and if they relate to assets that would otherwise be depreciable. In certain situations, where there is a sale or a lease-back or where the lease is determined to be a virtual purchase, we limit the recognition of the leases and rentals to what the ownership cost of the asset would be. Necessary and proper interest expense is includable in capital-related costs. I think this is a very important item. What "necessary" means to the program is that there must not be other provider funds available or there must not be other interest income generated by the provider before we would allow unlimited claiming of interest expense, so we do limit the recognition of interest expense.

As I mentioned, for proprietary providers a return on equity capital is allowed. As part of the prospective payment legislation, the return was 1½ times the rate of the trust fund obligations. It was reduced to one times the trust fund payment obligation rate only for inpatient hospital services.

Now, I would like to just briefly touch on the effect of these various policies over the last 18 years. In fiscal year 1984, the first year under the prospective payment system, inpatient operating expenditures are expected to total $39 billion. We estimate that inpatient capital expenditures will be about $3 billion. Of the $3 billion, $2.8 billion will be for depreciation and interest and $200 million will be for the return on equity capital.

So, capital expenditures in 1984 will represent about 7.4 percent of medicare payments for inpatient hospital operating costs. I would like to call your attention to the first chart here. (See chart No. 1.) Approximately 69 percent of medicare's payments for capital are for depreciation—14 percent for the movable assets and 55 percent for the fixed assets—24 percent is for interest costs, and 7 percent is for the return on equity.

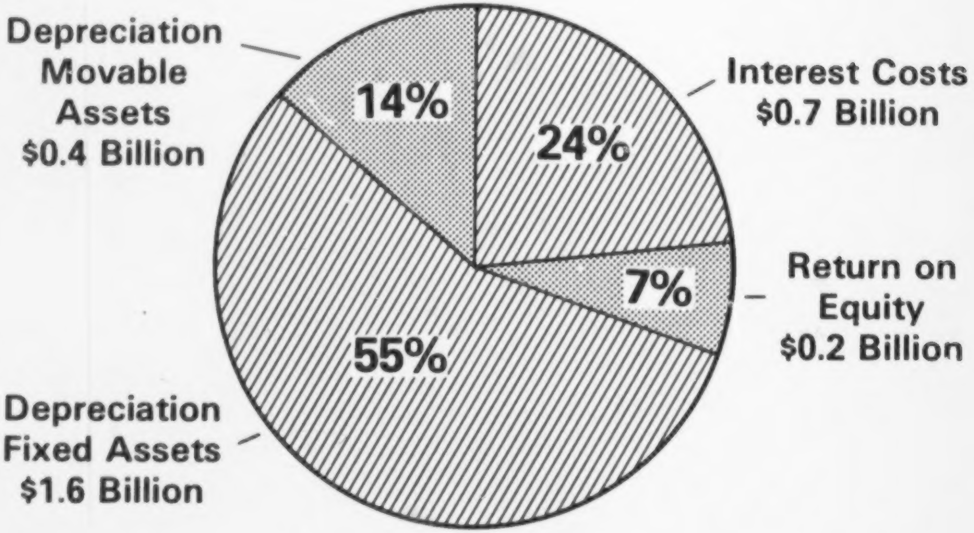
Our data also show—on chart No. 2—that the national figures on the relationship between capital and operating costs conceal considerable variation among hospitals. (See chart No. 2.) For roughly one-quarter of the hospitals, depreciation and interest is less than 4 percent of operating costs. Slightly over one-half of the hospitals claim depreciation and interest costs that are between 4 to 10 percent of operating costs. And just under one-fifth of the hospitals have ratios between 10 and 20 percent of operating costs. As you know, the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services is conducting a study of medicare payments for capital-related costs. A report is due to the Congress in October of this year, but obviously we do not know yet what the contents of that report will be.

[The charts referred to follow:]

CHART #1

Medicare Inpatient Capital Expenditures

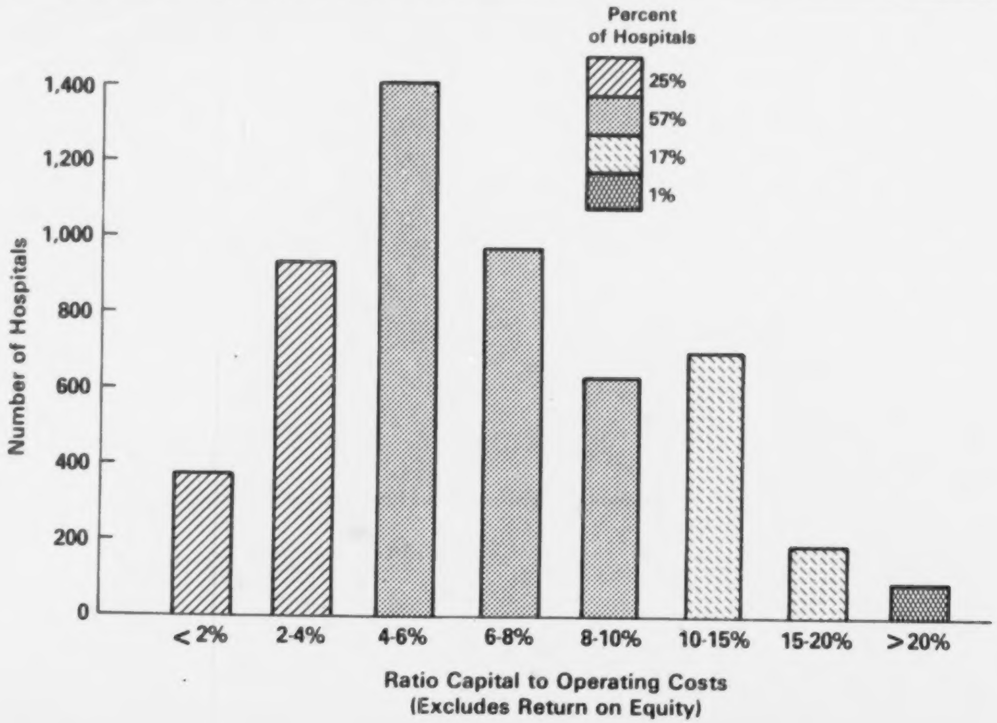
(FY 1984)



Total = $2.9 Billion

CHART #2

Community Hospitals: Distribution by Ratio of Capital to Operating Costs



Pg 11-6

Mr. **Streimer**. I thank you for the opportunity to explain our current system, and I would be glad to answer any questions you might have.

Senator **Durenberger**. Thank you.

[Mr. Streimer's prepared statement follows:]

TESTIMONY OF

ROBERT A. STREIMER
ACTING DEPUTY DIRECTOR
BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE
HEALTH CARE FINANCING ADMINISTRATION

I AM PLEASED TO BE HERE TODAY TO DISCUSS HOW THE MEDICARE PROGRAM CURRENTLY REIMBURSES PROVIDERS FOR CAPITAL-RELATED EXPENSES. NOW IS A PARTICULARLY GOOD TIME TO REVIEW OUR EXISTING PRACTICES, AS IN THE NEAR FUTURE WE MUST DECIDE HOW TO TREAT CAPITAL AS A PART OF THE NEW HOSPITAL PROSPECTIVE PAYMENT SYSTEM. AS YOU KNOW, CAPITAL-RELATED EXPENSES PRESENTLY ARE EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM AND WE CONTINUE TO FOLLOW ESSENTIALLY THE SAME PRINCIPLES ESTABLISHED AT THE BEGINNING OF MEDICARE OVER 18 YEARS AGO. OUR POLICIES ARE BASED ON THE REASONABLE COST REIMBURSEMENT PRINCIPLES EMBODIED IN SECTION 1861(V)(1)(A) OF THE SOCIAL SECURITY ACT.

THE PURPOSE OF REASONABLE COST REIMBURSEMENT OF CAPITAL-RELATED EXPENSES IS TO PAY ONLY FOR ACTUAL COSTS INCURRED WHICH ARE NECESSARY FOR THE EFFICIENT DELIVERY OF NEEDED HEALTH SERVICES. BECAUSE MEDICARE IS A PUBLICLY FINANCED PROGRAM, CARE MUST BE TAKEN TO ENSURE THAT THESE REIMBURSEMENTS ACCURATELY REFLECT THE COST OF CARE TO OUR BENEFICIARIES. IN ADDITION TO GENERAL ACCOUNTING STANDARDS IN THE PRIVATE SECTOR, THERE ARE SPECIFIC MEDICARE STANDARDS DUE TO THE PROGRAM'S UNIQUE RESPONSIBILITIES AND NEEDS.

THESE STANDARDS ARE AUTHORIZED BY THE MEDICARE STATUTE AND HAVE BEEN IMPLEMENTED THROUGH REGULATIONS AND OUR PROVIDER REIMBURSEMENT MANUAL.

BACKGROUND -- CURRENT POLICY

AS I NOTED, UNDER THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM CAPITAL-RELATED EXPENSES CONTINUE TO BE PAID ON A COST REIMBURSEMENT BASIS. THE CAPITAL-RELATED COSTS WHICH MEDICARE RECOGNIZES INCLUDE:

- DEPRECIATION OF ASSETS BASED ON THE HISTORICAL COST OF THE ASSET PRORATED OVER THE ASSETS' USEFUL LIFE (LESS SALVAGE VALUE);
- LEASES AND RENTALS FOR THE USE OF ASSETS THAT WOULD BE DEPRECIABLE IF THE PROVIDER OWNED THEM OUTRIGHT;
- THE COST OF IMPROVEMENTS;
- THE COST OF MINOR EQUIPMENT WHICH IS CAPITALIZED RATHER THAN EXPENSED;

- O NECESSARY AND PROPER INTEREST EXPENSE FOR LOANS USED TO ACQUIRE LAND OR DEPRECIABLE ASSETS USED FOR PATIENT CARE, AND CERTAIN INSTANCES OF REFINANCING EXISTING DEBT;

- O TAXES ON LAND OR DEPRECIABLE ASSETS USED FOR PATIENT CARE;

- O INSURANCE EXPENSE FOR DEPRECIABLE ASSETS USED FOR PATIENT CARE; AND

- O FOR PROPRIETARY PROVIDERS ONLY, A REASONABLE RETURN ON EQUITY CAPITAL.

SINCE THE CREATION OF MEDICARE, THERE HAVE BEEN SEVERAL MODIFICATIONS IN THE TREATMENT OF CAPITAL REFLECTING CHANGES IN CAPITAL MARKETS AND THE INCREASING COMPLEXITY OF THE PROGRAM. WHEN THE PROGRAM BEGAN ON JULY 1, 1966, CAPITAL-RELATED COST REIMBURSEMENT INCLUDED ALL THE ELEMENTS DESCRIBED ABOVE, EXCEPT A RETURN-ON-EQUITY CAPITAL.

FROM THIS BASE THE FOLLOWING MAJOR LEGISLATIVE AND REGULATORY CHANGES IN THE TREATMENT OF ALLOWABLE CAPITAL COSTS OCCURRED:

NOVEMBER 1966: ADDED RETURN ON EQUITY CAPITAL FOR PROPRIETARY PROVIDERS TO COMPENSATE INVESTOR-OWNED HOSPITALS FOR ECONOMIC COSTS OF ACQUIRING NEEDED EQUITY CAPITAL.

AUGUST 1969: ESTABLISHED APPRAISAL GUIDELINES FOR ASSETS FOR PROVIDERS THROUGH AN INTERMEDIARY LETTER TO ASSURE ACCURATE COMPUTATION OF THE HISTORICAL COST OF ASSETS.

AUGUST 1970: PROHIBITED THE USE OF ACCELERATED METHODS OF DEPRECIATION, WITH CERTAIN EXCEPTIONS, TO PREVENT PROGRAM ABUSES ASSOCIATED WITH RAPID DEPRECIATION AND RESALE OF THE PROPERTY, AND REMOVED GOODWILL FROM COMPUTATION OF RETURN ON EQUITY FOR PURCHASES OR ACQUISITIONS ON OR AFTER AUGUST 1, 1970 TO CONTAIN CAPITAL COSTS.

JULY 1979: EXCLUDED CAPITAL-RELATED COSTS FROM INPATIENT ROUTINE COST LIMITS

FOR COST REPORTING PERIODS ON OR AFTER JULY 1, 1979.

OCTOBER 1982: EXCLUDED CAPITAL-RELATED COSTS FROM THE TOTAL COST LIMITS ON HOSPITAL INPATIENT OPERATING COSTS TO CONFORM TO THE STATUTE.

APRIL 1983: REDUCED THE RETURN ON EQUITY PAID FOR INPATIENT HOSPITAL SERVICES FROM ONE-AND-ONE-HALF TIMES TO ONE TIMES THE INTEREST EARNED ON THE TRUST FUNDS TO CONFORM TO CHANGES IN THE STATUTE.

AUGUST 1983: PROHIBITED THE USE OF THE INTERNAL REVENUE SERVICE ACCELERATED COST RECOVERY SYSTEM (ACRS) IN ESTABLISHING THE USEFUL LIVES OF DEPRECIABLE ASSETS, BECAUSE ACRS IS NOT A TRUE MEASURE OF USEFUL LIFE.

OCTOBER 1983: RETAINED TEMPORARILY COST REIMBURSEMENT FOR CAPITAL-RELATED COST WHILE THE NEW PROSPECTIVE SYSTEM WAS BEING PHASED IN OVER THREE YEARS.

EXPLANATION OF CURRENT ALLOWABLE CAPITAL COSTS

PRIOR TO IMPLEMENTATION OF THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM, A PROVIDER'S CAPITAL-RELATED COSTS WERE TREATED AS OVERHEAD COSTS USUALLY ALLOCATED ON THE BASIS OF SQUARE FOOTAGE. THE CAPITAL-RELATED COSTS WERE THEN APPORTIONED FOR REIMBURSEMENT PURPOSES BETWEEN MEDICARE AND NON-MEDICARE.

UNDER PROSPECTIVE PAYMENT, CAPITAL-RELATED COSTS ARE SEPARATELY ACCUMULATED AND APPORTIONED TO MEDICARE TO BE PAID ON A RETROSPECTIVE COST BASIS. BECAUSE CAPITAL-RELATED COSTS ARE NOW PAID ON A DIFFERENT BASIS THAN INPATIENT OPERATING COSTS, THE ELEMENTS OF CAPITAL-RELATED COSTS HAVE BEEN MORE SPECIFICALLY DEFINED IN OUR RECENT PROSPECTIVE PAYMENT REGULATIONS AS FOLLOWS:

> "CAPITAL-RELATED COSTS AND ALLOWANCES FOR RETURN ON EQUITY ARE LIMITED TO THE FOLLOWING: (1) NET DEPRECIATION EXPENSE . . . (2) TAXES ON LAND OR DEPRECIABLE ASSETS USED FOR PATIENT CARE; (3) LEASES AND RENTALS. . . (4) THE COSTS OF BETTERMENTS

> AND IMPROVEMENTS. . . (5) THE COSTS OF MINOR EQUIPMENT THAT ARE CAPITALIZED, RATHER THAN EXPENSED. . . (6) INSURANCE EXPENSE ON DEPRECIABLE ASSETS. . . (7) INTEREST EXPENSE. . . (8) FOR PROPRIETARY PROVIDERS, RETURN ON EQUITY CAPITAL. . . (9) THE CAPITAL-RELATED COSTS OF RELATED ORGANIZATIONS. . ."

DEPRECIATION

DEPRECIATION EXPENSE IS LIMITED TO THE HISTORICAL COST OF THE ASSET DEPRECIATED OVER ITS ESTIMATED USEFUL LIFE. WHERE AN ONGOING FACILITY IS ACQUIRED BY PURCHASE OR MERGER, THE HISTORICAL COST IS DEFINED AS THE LEAST OF THE PRICE PAID, THE FAIR MARKET VALUE, OR THE CURRENT REPRODUCTION COST DEPRECIATED ON A STRAIGHT-LINE BASIS TO THE TIME OF THE SALE. IN ESTABLISHING USEFUL LIFE, PROVIDERS MUST USE REASONABLE USEFUL LIFE GUIDELINES APPROVED BY THE SECRETARY. DEPRECIATION EXPENSE INCLUDES DEPRECIATION ON BUILDING AND FIXTURE IMPROVEMENTS, AND MAJOR MOVEABLE EQUIPMENT AND MINOR EQUIPMENT WHERE THE POLICY OF THE PROVIDER IS TO CAPITALIZE MINOR EQUIPMENT.

DEPRECIATION EXPENSE MUST BE ADJUSTED BY GAINS OR LOSSES REALIZED FROM THE DISPOSAL OF DEPRECIABLE ASSETS, AS WELL AS BY THE RECOVERY OF ACCELERATED DEPRECIATION, AS NECESSARY. ACCELERATED METHODS OF DEPRECIATION MAY NOT BE USED FOR ASSETS ACQUIRED AFTER JULY 31, 1970, EXCEPT WHERE THE CASH FLOW FROM STRAIGHT-LINE DEPRECIATION IS INSUFFICIENT TO MEET REASONABLE PRINCIPAL AMORTIZATION SCHEDULES, IN WHICH CASE THE DECLINING BALANCE METHOD, NOT TO EXCEED 150 PERCENT OF THE STRAIGHT-LINE METHOD, MAY BE USED.

A PROVIDER MAY INCLUDE IN ITS CAPITAL-RELATED COSTS THE COSTS OF INSURANCE ON DEPRECIABLE ASSETS USED FOR PATIENT CARE OR INSURANCE THAT PROVIDES FOR THE PAYMENT OF CAPITAL-RELATED COSTS DURING BUSINESS INTERRUPTION. TAXES ON LAND OR DEPRECIABLE ASSETS USED FOR PATIENT CARE ARE ALSO AN ELEMENT OF CAPITAL-RELATED COSTS.

LEASES AND RENTALS

THE COST OF LEASES AND RENTALS MAY BE INCLUDED IN CAPITAL-RELATED COSTS IF THEY RELATE TO

ASSETS USED FOR PATIENT CARE THAT WOULD BE DEPRECIABLE IF THE PROVIDER OWNED THEM OUTRIGHT. IN CERTAIN SALE AND LEASEBACK TRANSACTIONS AND IN SITUATIONS WHERE THE LEASE IS A VIRTUAL PURCHASE, THE LEASE OR RENTAL CHARGE MAY BE LIMITED TO THE COSTS OF OWNERSHIP (STRAIGHT-LINE DEPRECIATION, INTEREST EXPENSE, INSURANCE AND TAXES).

INTEREST

NECESSARY AND PROPER INTEREST EXPENSE IS INCLUDABLE IN CAPITAL-RELATED COSTS, IF SUCH EXPENSE IS INCURRED IN (1) ACQUIRING LAND AND/OR DEPRECIABLE ASSETS USED FOR PATIENT CARE, OR (2) REFINANCING EXISTING DEBT, IF THE ORIGINAL PURPOSE OF THE REFINANCED DEBT WAS TO ACQUIRE LAND AND/OR DEPRECIABLE ASSETS USED FOR PATIENT CARE. TO ASSURE THE NECESSITY OF INTEREST EXPENSE, INVESTMENT INCOME MUST BE USED TO REDUCE INTEREST EXPENSE, EXCEPT WHERE SUCH INVESTMENT INCOME IS FROM UNRESTRICTED GIFTS OR GRANTS, FUNDED DEPRECIATION, OR A PROVIDER'S QUALIFIED PENSION FUND.

RETURN ON EQUITY CAPITAL

FOR PROPRIETARY PROVIDERS, A RETURN ON EQUITY CAPITAL IS ALLOWED. FOR INPATIENT HOSPITAL REIMBURSEMENTS, THIS RETURN IS DETERMINED BY APPLYING TO THE PROVIDER'S EQUITY CAPITAL (EXCESS OF PATIENT-CARE-RELATED ASSETS OVER PATIENT-CARE-RELATED LIABILITIES) A PERCENT EQUAL TO THE AVERAGE RATES OF INTEREST ON SPECIAL ISSUES OF PUBLIC DEBT OBLIGATIONS ISSUED TO THE FEDERAL HOSPITAL INSURANCE TRUST FUND.

CAPITAL EXPENDITURES

IN FISCAL YEAR 1984, THE FIRST YEAR UNDER THE NEW PROSPECTIVE PAYMENT SYSTEM, EXPENDITURES FOR INPATIENT HOSPITAL SERVICES ARE EXPECTED TO TOTAL $39 BILLION. BASED ON PAST EXPERIENCE, WE ESTIMATE THAT INPATIENT CAPITAL-RELATED EXPENDITURES WILL BE ABOUT $2.9 BILLION. OF THIS TOTAL, $2.7 BILLION WILL BE FOR DEPRECIATION AND INTEREST AND $200 MILLION FOR RETURN ON EQUITY. CAPITAL EXPENDITURES WILL THEREFORE REPRESENT ABOUT 7.4 PERCENT OF MEDICARE PAYMENTS FOR INPATIENT HOSPITAL OPERATING COSTS.

APPROXIMATELY 69 PERCENT OF MEDICARE'S PAYMENTS FOR CAPITAL ARE FOR DEPRECIATION, 24 PERCENT FOR INTEREST, AND 7 PERCENT FOR RETURN ON EQUITY. A PRELIMINARY ALLOCATION OF DEPRECIATION SUGGESTS THAT ALMOST 80 PERCENT IS FOR FIXED ASSETS, AND 20 PERCENT FOR MOVABLE ASSETS. OUR DATA ALSO SHOW THAT NATIONAL FIGURES ON THE RELATIONSHIP BETWEEN CAPITAL AND OPERATING COSTS CONCEAL CONSIDERABLE VARIATION AMONG HOSPITALS. FOR ROUGHLY ONE QUARTER OF THE HOSPITALS, DEPRECIATION AND INTEREST IS LESS THAN 4 PERCENT OF OPERATING COSTS. SLIGHTLY OVER ONE HALF OF THE HOSPITALS CLAIM DEPRECIATION AND INTEREST THAT IS BETWEEN 4 AND 10 PERCENT OF OPERATING COSTS. JUST UNDER ONE FIFTH HAVE RATIOS BETWEEN 10 AND 20 PERCENT.

CURRENT POLICY DEVELOPMENT ACTIVITIES

AS YOU KNOW, THE THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION IS CONDUCTING A STUDY OF MEDICARE PAYMENT FOR CAPITAL-RELATED COSTS, AS REQUIRED BY P.L. 98-21, WITH A REPORT DUE TO CONGRESS IN OCTOBER 1984. OBVIOUSLY, WE DO NOT KNOW WHAT THE OUTCOME OF THAT STUDY WILL BE AT THIS TIME.

I THANK YOU FOR THE OPPORTUNITY TO EXPLAIN OUR CURRENT SYSTEM OF PAYING FOR CAPITAL-RELATED EXPENSES. I WILL BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

Senator **Durenberger**. Let me just start with that since you have got it up there. Do you have information that would be helpful to us about why certain people fall in the green and fall in the blue so that we don't come to the obvious conclusion?

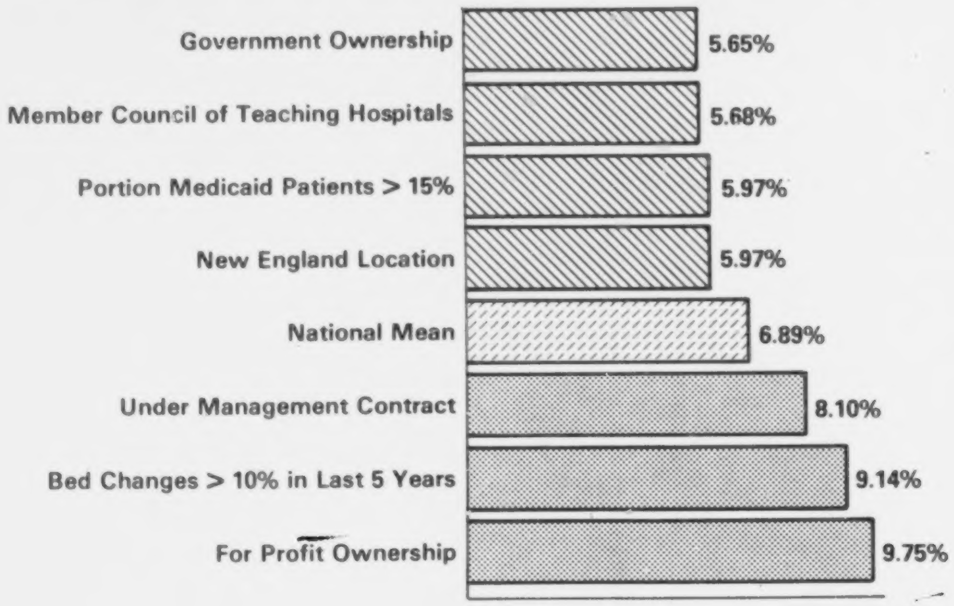
Mr. **Streimer**. There are two things I would like to mention here. One is that of all the data we have looked at, the one aspect that seems to be most determinative of these percentages is the age of the facility—the age of the physical plant. Now, we have chart No. 3 that shows certain characteristics of the hospitals by the ratio of capital-to-operating costs. (See chart No. 3.) Now, I don't think we can predict that these are determinative, nor why they occur this way. I think age of facility is the most clear determining factor. However, I think some of these ratios are quite interesting. We would expect Government and teaching hospitals to tend to be older hospitals. They also may tend to have higher operating costs, which might cause the percentage to be lower. We don't know yet what is causing that. Clearly, the hospitals that have added beds, that are under management contracts, and that are under management contracts, and that are under for-profit ownership have higher ratios and also tend to be the newer hospitals.

[The chart referred to follows:]

Pg. 13-a

CHART #3

Hospital Characteristics Associated with Lower and Higher Ratios of Capital to Operating Costs



(Excludes Return on Equity)

Senator DURENBERGER. Am I reading that correctly now—the 5.65 percent is the lowest and the 9.75 percent is the highest?

Mr. STREIMER. Just by these breakdowns of characteristics. There are hospitals that have much lower——

Senator DURENBERGER. These are the same percentages, though, that we were dealing with——

Mr. STREIMER. That is correct. This is the percent of capital as a percent of operating costs.

Senator DURENBERGER. OK. To what degree do you arrive at those figures on the basis of the kind of determinants you just ran through in your testimony as to what you consider to be reimbursable capital versus some other figure? Explain to me how you get the 5.65 percent generally on Government ownership? What do you take into that consideration?

Mr. STREIMER. OK. That is the total of depreciation, interest, leases, and rentals—all the elements of capital costs—added up and a percent of the operating cost.

Senator DURENBERGER. So, how does a county in Minnesota get reimbursed for—not get reimbursed—but how do they factor in depreciation, or do they? A county-owned hospital facility?

Mr. STREIMER. Its depreciation is recorded as any other hospital.

Senator DURENBERGER. Just as any other?

Mr. STREIMER. Yes. They would tend to have older plants than some of the newer hospitals. Most of the governmentals are older facilities, but generally, governmental facilities have a very elaborate process through the State budget office that allocates all of the physical plant and operating expenses that are attributable to their individual hospitals.

Senator DURENBERGER. OK. So, when we use the term "depreciation," we can reliably apply that definition across the board to Government, not-for-profits, for-profits, and whatever else may be eligible.

Mr. STREIMER. That is correct.

Senator DURENBERGER. Now, is the same thing true of interest?

Mr. STREIMER. Yes. Now, one thing that may help explain some of the difference is that newer facilities cost more money, so the amount of depreciation is likely to be higher. Newer loan obligations carry with them higher interest rates, so the amount of the interest is likely to be higher. The categorization of the expense is the same though.

Senator DURENBERGER. OK. So, I can rely on that to try to figure out the differences among these various hospitals on the fact that the base definition is the same.

Mr. STREIMER. Yes.

Senator DURENBERGER. Only the entity's access to capital or the age of a facility or perhaps a few other lesser factors will account for some of these distinctions.

Mr. STREIMER. That is correct.

Senator DURENBERGER. OK. Let me ask you a question about depreciation versus debt service or interest, and this is just by way of getting you to explain to me what is going on. I guess I view depreciation as, say, sort of a measure of past experience transactions that have taken place and events that have taken place. And in debt service—or the interest category—it is more a reflection of future capabilities—some reflection of your ability to generate income in the future. Am I right then in making the judgment that to the degree that we limit or put limits on operating income from a medicare standpoint, we are raising the cost of capital? I hate to ask you an obvious question.

Mr. STREIMER. I think it is a difficult question to answer. Some of the anecdotal information that I have seen would indicate that it cuts both ways in those instances where it would help reduce operating costs by making a capital investment—I think that is probably a great incentive to try and do that right now. For those kinds of investments that might increase admissions or services, I think there is probably an incentive which is probably unfortunate at the present time, just because capital is not within the system. I don't think you could generalize much beyond that, though.

Senator DURENBERGER. OK. How about size, and again I am asking the kinds of questions that I probably should be asking somebody from a bond-rating service or something. But I read this CRS report that Glenn Marcus put together in which he said that the cost of capital was substantially lower for large hospitals—that is, measured in terms of number of beds—than it is for small hospitals.

Does the size appear to be a factor in determining the cost of the capital?

Mr. STREIMER. I have no knowledge of whether it is a determininant for the cost of capital. It clearly is highly correlated with the amount of expense that is recognized by the health insurance programs. Obviously, the larger hospitals cost more in terms of absolute dollars.

Senator DURENBERGER. And again, looking at it in terms of the debt service as a measurement of the cost of capital—if you look at a hospital, and you find a history and probably a future of substantial subsidies that is to serve medicare patients, to serve—I shouldn't refer to that as a subsidy because we are adequately compensating people for that—but you find a lot of medicare patients and medicaid, uninsured, a variety of other economically underserved people going through the system. Do you also find in those kinds of hospitals a greater cost of capital, measured in terms of the debt service portion of their capital costs?

Mr. STREIMER. I think one of the indicators here is where we see that hospitals with a high percentage of medicaid patients tend to have a lower capital ratio. Now, again, I am not sure what causes that. They probably tend to be the older facilities, so they have a lower ratio for that reason. They could also tend to be more expensive hospitals with respect to their operating costs and that may cause the ratio to be lower also.

Senator DURENBERGER. OK. There will be some testimony later on this morning about the fact that our fears that the capital problem is going to explode in our faces if we didn't limit it in some way are unfounded because of the fact that we are obviously putting some limitations on operating expenses. And the argument will be made that the acquisition of capital assets has a corollary driving force on raising operating expenses. Do you subscribe to that?

Mr. **Streimer**. The studies seem to be all over the place as to what the numbers are. One study I have looked at, which indicates there is a wide range, is that for every dollar spent on capital, there is an increase of 22 cents in operating costs.

Senator **Durenberger**. 22 cents?

Mr. **Streimer**. 22 cents.

Senator **Durenberger**. Another thing that I referred to in my opening statement that bothers me somewhat—that you may or may not have an observation about—is that a substantial capital investment, particularly in fixed assets, is one of those forces that stands in the way of some institutions making decisions about major alterations and how they deliver service. In other words, you are sitting there with a $50 million investment and you just can't get out of the business because you have got a commitment to repay in one way or another that huge investment. So, naturally, as you look across America today and you see some of this competition taking place, you find efforts on the part of a lot of institutions to find ways to generate other income. If they lose some business here, they will try to get into another line of business.

Wherever you look at that, then you find the mutual sharing arrangements and people can follow that, but nobody wants to give up those big buildings, and it strikes me that they don't want to give them up because they have got a commitment to somebody to repay that investment.

Do you have any thoughts on whether or not that is a realistic problem out there, and what, if anything, public policy might do to make some of those decisions easier to make?

Mr. **Streimer**. I have no suggestions on what we might do by way of public policy. It is interesting to note that there is a fairly substantial number of sales of institutions that would seem to indicate, in part, that institutions aren't sitting idly by because someone does not want to operate them any longer.

Senator **Durenberger**. A couple of other questions. One, you mentioned the valuation of leases and made some reference to the fact that certain leases might be treated as sales. With regard to the determination—that particular determination or any other determination relative to leasing versus ownership—are you guided in your determinations by current tax laws—IRS interpretations on that subject?

Mr. **Streimer**. In the area of depreciation of leases, which we have written extensively about over the last 18 years, situations generally don't exist that haven't been covered in the medicare manuals with respect to asset valuations and leases. If there were an instance of something that came along that we hadn't addressed in 18 years, we would first look to generally accepted accounting principles for guidance and possibly look to the tax laws, though we are not bound by them in any way.

Senator **Durenberger**. You are not?

Mr. **Streimer**. No.

Senator **Durenberger**. OK. When we get to the testimony of the Federation of American Hospitals, we are going to hear a couple of comments that I will ask you about before I ask them about it. One is investor-owned hospitals cannot accept philanthropy—do you know that to be a fact?

Mr. STREIMER. No, I don't.

Senator DURENBERGER. Another is that investor-owned hospitals cannot issue tax-free debt. I take it that means that they are not in the same position as a governmental institution, but is there any reason why an investor owned hospital does not have access to tax-exempt financing through some of the traditional tax-exempt vehicles?

Mr. STREIMER. It is my understanding that—I am not clear on the tax-exempt laws—there are industrial development bonds which are tax exempt that are available to any business or institution. I also understand that there is a program run by the Federal Housing Administration—the 242 program—which is also available to all entities, regardless of their ownership. I believe that subsidizes interest rates.

Senator DURENBERGER. Then, there is another statement that we can go into more with the representatives of investor-owned hospitals, but it indicates that there is a diminishing in the tax payment deferral capability of investor-owned hospitals. And I assume that is sort of a historic statement. Can you give us some indication of how you perceive the investor-owned hospital income taxes as opposed to property taxes paid over the last 5 years and then for the future?

Mr. STREIMER. It has been a longstanding medicare policy since the beginning of the program that income taxes are not recognizable under medicare as an expenditure, so they are correct that, at the end of their figuring the results of their operation for the year, they—unlike other hospitals—do indeed pay income taxes. The medicare program does not recognize that that has occurred.

Senator DURENBERGER. But they have a little thing at the bottom of that chart called return on equity?

Mr. STREIMER. That is correct.

Senator DURENBERGER. And isn't it a fact that at least in some substantial part, that return on equity is there to reflect the absence of what you just testified to?

Mr. STREIMER. I believe that historically the return on equity was developed as a means to pay proprietary institutions for keeping their capital in the health care system, as opposed to putting it somewhere else where they could get the same return. I have never heard it articulated in such a way that it would be in lieu of income taxes.

Senator DURENBERGER. I guess what I am getting at is do you have——

Mr. STREIMER. There are certainly pluses and minuses, and capital is certainly on the plus side, and the fact that they pay income taxes I would say would be on the minus side.

Senator DURENBERGER. Do you have records on income taxes paid by investor-owned——

Mr. STREIMER. Not to by knowledge, no.

Senator DURENBERGER. OK. Do you know to what degree some other major third-party payers—for example, Blue Cross—use comparable costs—capital costs—for reimbursement?

Mr. STREIMER. I am not completely sure. My understanding is that some Blue Cross plans do and many do not. I do not know the breakdown.

Senator DURENBERGER. OK. Thank you very much, Bob. I appreciate your testimony.

Our next witnesses will be a panel on behalf of the American Hospital Association—Jack W. Owen, executive vice president; Charles O'Brian, administrator of Georgetown University Hospital, Washington; and Gordon Butler, administrator of the Memorial Community Hospital in Jefferson City, MO.

And on behalf of the Catholic Association of the United States, John Curley, Jr., president of the Catholic Health Association, and Sister Geraldine Hoyler, vice president for finance, the Holy Cross Health System, South Bend, IN.

We welcome all of you and look forward to your comments. We have written testimony from both of you, and you may feel free to elaborate on that testimony and add any other comments that you might have in response to previous testimony or questions, so that we can use our time together here this morning to learn as much as we can about your views on capital.

We will proceed first with Jack Owen. We will go in the order that people were introduced.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. OWEN. Thank you, Senator. I am Jack Owen, executive vice president of the American Hospital Association, and we represent about 6,300 hospitals.

You have my statement, and I am not going to go into that. You have had a chance to read it. I would like to reserve more time when you get to the point of deciding how you are going to handle capital rather than use the time this morning on what is occurring, and I have two very good witnesses here—one from a small hospital and one from a university hospital—whom I think can answer the questions as to what is occurring in their institutions.

I think it is important just to stress again that capital is an important issue to the American Hospital Association and to all of its hospitals. I think we have to keep in mind, however, that the price that is set by the DRG system for the operational side must be kept adequate if we are going to maintain capital no matter what kind of a system we finally come up with.

I would just say also that we have taken a position and feel that capital should be part of that price, and that capital should contain two things—a return of capital and a return on capital. And with that, I would like to turn it over to Mr. Butler, who is the administrator of a city hospital—a small hospital—in Jefferson City, MO, and Mr. O'Brian, who is administrator of Georgetown University Hospital—two hospitals which raise capital in different fashions that have different kinds of problems, but I think can answer some of your questions.

And maybe with that, Mr. Butler could start off.

Senator DURENBERGER. OK.

[Mr. Owen's prepared statement follows:]

American Hospital Association

444 North Capitol Street N.W.
Suite 500
Washington D.C. 20001
Telephone 202.638.1100
Cable Address: Amerhosp

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE COMMITTEE ON FINANCE
ON
CAPITAL FINANCING UNDER MEDICARE

March 9, 1984

SUMMARY

The American Hospital Association (AHA) supports, in principle, replacing the current Medicare policy of a cost pass-through for capital-related expenses with a method that incorporates capital costs into Medicare prospective prices.

However, it is very important to note that this position includes two caveats. If these two conditions are not met, the AHA could not support the incorporation of capital-related costs into Medicare prospective prices. First, diagnosis-related group (DRG) prices for operating expenses must be both adequate and equitable. Second, the aggregate amount of capital to be made available under the Medicare program must be sufficient to ensure that all well-managed hospitals are able to meet the needs of their communities.

In addition to these two caveats, the AHA position includes three broad principles that any specific method for incorporating capital-related costs into Medicare prospective prices must recognize. These principles include: (1) recognizing that a hospital's capital-related costs involve a return of capital and a return on capital; (2) acknowledging that a transition period will be necessary; and (3) recognizing that, except for a transition period, capital payments should not vary as a result of management decisions. In addition, the Association believes that incorporating capital-related costs into Medicare prospective prices makes unnecessary a federal role in state capital expenditure regulation.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, executive vice president and director of the Washington Office of the AHA. The Association, which represents approximately 6,300 institutions and more than 35,000 personal members, appreciates the opportunity to appear before the subcommittee and present some of its views in regard to capital financing under the Medicare program. I am accompanied by Gordon H. Butler, administrator of Memorial Community Hospital of Jefferson City, Missouri.

As you know, the recently enacted Social Security Amendments of 1983, P.L.98-21, established a prospective pricing system for the Medicare program based on DRGs. The AHA worked closely with the Congress to develop this program and views it as a significant step in system reform. The Association is absolutely committed to ensuring that the system works properly and achieves the goals that we all share of providing incentives for efficiency without compromising quality care.

Under the provisions of P.L.98-21, payment for capital costs, which include depreciation, interest, and, for investor-owned hospitals, return on equity, continues on a retrospective cost basis. However, the Secretary of the Department of Health and Human Services (HHS) is required to complete a study by October 1984, on methods and proposals to include capital-related costs in the prospective prices.

AHA POSITION ON CAPITAL-RELATED PAYMENTS

The AHA has been carefully examining the issue of how Medicare should treat capital-related costs. On February 1, 1984, the AHA House of Delegates endorsed a position that supports, in principle, replacing current Medicare policy of a cost pass-through for capital-related expenses with a method that incorporates capital costs into Medicare prospective prices. Conceptually, the Association believes that prospective pricing for capital represents a logical next step in the development of a payment system that provides hospitals with a consistent set of management incentives for cost-effective performance.

However, it is important to note that the AHA's position on capital-related payments includes two caveats. If these two conditions are not met, the AHA could not support the incorporation of capital-related costs into Medicare prospective prices.

First, DRG prices for operating expenses must be both adequate and equitable.

Second, the aggregate amount of capital to be made available under the Medicare program must be adequate to ensure that all well-managed hospitals are able to meet the needs of their communities.

In addition to these two caveats, the AHA position includes three broad principles that any method for incorporating capital-related costs into Medicare prospective prices must recognize.

Return of Capital/Return on Capital

First, a hospital's cost of capital is composed of a return of capital and a return on capital, regardless of the source of capital.

The term return of capital is used to describe any economic entity's cost of "consuming" capitalized assets. In accounting terms, this is depreciation expense and is intended to replace the capital invested, rather than the assets themselves.

The term return on capital denotes the cost of using money, whether from debt or equity sources. This cost includes the time value of money such as inflation, and also reflects factors such as opportunity cost and risk. For borrowed capital, this cost is easily identifiable as interest expense. For investor-owned hospitals, the cost of equity capital is expressed as dividends and capital gains to investors. For nonprofit hospitals, the cost of equity capital is expressed as the services returned to the community (such as free care, specialty, and low-volume services) and the demonstrated capacity to remain fiscally viable in order to continue to serve the community and meet its future expectations.

Under a competitive pricing system, hospitals would individually set prices to balance operating and capital costs against market forces. However, for Medicare capital-related payments to be adequate, they must satisfy the well-managed hospital's need for both a return of capital and return on capital. This is because, under the Medicare payment system, prices are set administratively and are increasingly based on averages. Thus, a minimum cost of equity capital must be explicitly factored into Medicare payments. If a return on equity capital were required to be recovered totally by keeping operating costs below DRG prices, the average-performing hospital would be unable to recover its cost of equity capital in treating Medicare patients.

Transition Period

Second, the AHA strongly believes that a mechanism will be necessary to recognize and account for the transitional needs of hospitals that have recently incurred substantial capital expenditures or may soon incur such expenditures because of codes, standards, and/or other compliance requirements as well as capital requirements associated with increases in community service needs.

Movement from a cost pass-through method to a consolidated price constitutes a major change in Medicare capital-related payments--so significant that the administrative benefits and incentives occurring from such a change can easily be lost if an adequate transition mechanism is not provided. Hospitals making major capital expenditures incur financial obligations over extended periods of time. Absent an adequate transition mechanism, hospitals may not be able to satisfy these obligations, and future access to capital may be jeopardized.

Uniform Payments

Third, except for transitional needs, the Association believes that capital-related payments should not vary as a result of management decisions with respect to such matters as ownership, tax status, capital-labor mix, and debt-versus-equity financing decisions. Inherent in the movement toward the prospective pricing system is the notion that prices should not vary due to hospital characteristics that reflect discretionary decisions by hospital management. Therefore, it is important that payments for capital-related costs not bias, as they have in the past, management decision-making with respect to the above noted matters.

CAPITAL EXPENDITURE REGULATION

The AHA position also states that incorporating capital-related payments into Medicare prospective prices makes a federal role in state capital expenditure regulation unnecessary. If capital is to be included in prospective prices, hospitals will be fully "at risk" for their capital expenditure decisions. Thus, the Association strongly believes that the role of the federal government in state capital expenditure review programs should be eliminated.

CONCLUSION

With these caveats and principles in mind, the AHA will continue to work with other hospital organizations, HHS, and the Congress to identify the most appropriate method to incorporate capital-related costs into Medicare prospective prices. Among the alternative methods that will be considered are a uniform vs. DRG-specific percentage add-on and whether the capital-related payment factor should be an industry-wide average, or should be based on asset age, region, or other hospital characteristics.

In addition, the AHA will consider whether a phase-in based on the blending of hospital-specific capital costs with federal capital-incorporated DRG rates is preferable to a "floor payment" phase-in that would allow hospitals to choose annually between either a cost pass-through payment for capital ("old" and "new" capital meeting certain requirements) or DRG prices that include capital. Under a "phase-in" approach, in the initial year, the Association believes that capital payments should be based largely, but not solely, on the hospital's own costs, shifting over time to a heavier weighting on the average capital payment factor.

The AHA recognizes that incorporating capital-related costs into the Medicare prospective pricing system will result in differences from past practices that require adjustments in management planning, expectations, and actions. However, the Association believes that, when the issue is examined within the context of the nation's changing priorities and the changing environment of health services delivery and financing, and when contrasted with the other alternatives, incorporating capital-related costs into prospective prices makes sense.

While having some surface attractiveness, a pass-through approach is seen to offer no real financial security for either hospitals or investors, as it provides no real access-to-capital guarantees, and at the same time limits management flexibility and subjects the hospital to the risks of a regulatory capital allocation process. Thus, the AHA believes that the incorporated approach is better, provided that the conditions of adequate and equitable DRG prices and an adequate capital payment formula are met.

STATEMENT OF GORDON H. BUTLER, ADMINISTRATOR, MEMORIAL COMMUNITY HOSPITAL, JEFFERSON CITY, MO

Mr. **Butler**. Thank you. I will be happy to answer any questions you might have.

Senator **Durenberger**. Why don't you just tell us a little bit about your own facility and some of the problems that you have in raising capital and what your views are on some of the problems in the public policy area that relate to your own situation.

Mr. **Butler**. We are a 91-bed hospital in rural Missouri in a community of 35,000, and we have used capital three times in the last 8 years for modernization. At the present time, our hospital has an unusually high rate of medicare activity at 64 percent, and we have found that one of the major reasons for the use of capital is to use it to modernize the hospital and also to come up with the expanded service. And the only restriction that we have had in the area of the capital financing market has been in the area of—because of our size being less than 100 beds—the rating agencies automatically decrease what our rating is in an arbitrary fashion, and that happened 3 years ago. The hospital does not use tax-exempt financing because we found it to be disadvantageous to our situation, and this is also the result of timing the markets and a court decision that was necessary in our State to rule on the decision of separation of church and State and the way the legislation was passed.

Senator **Durenberger**. That kept you from using IDB's?

Mr. **Butler**. It did initially. In the timing of events, we were not in a position to use it at that point in time.

Senator **Durenberger**. Are you in the church business or the State business?

Mr. **Butler**. As a State. The problem was resolved shortly thereafter, and the authority was then opened to do business with hospitals, but then there was such a backlog that it impeded our progress in the situation, and we did not elect to. The other aspect of it was the fact that we have always used public bonds, and one of the stipulations—because of our indebtedness structure—was that we would have to refinance. And when we were doing this—considering tax-exempt issues—some time in the past, the bond market at that time—the interest rates were approximately 15 to 16 percent, and the rate that we had on our outstanding debt was around 9¼, and it certainly was not advantageous for us to make any change at that time.

Senator **Durenberger**. Just one more question. Are you in the market for working capital as well?

Mr. **Butler**. Not at the present time. We just finished an issue this last July, and so we do not have any need at the present time.

Senator **Durenberger**. Was that for working capital?

Mr. **Butler**. That is correct.

Senator **Durenberger**. Chuck, do you want to add your comments? And while you are talking, tell me why you think the folks that are members of the Council of Teaching Hospitals might have such a low rate of working capital—it must be because the operating that is so high—is that right? [Laughter.]

[Mr. Butler's prepared statement follows:]

MEMORIAL
COMMUNITY
HOSPITAL
1432 Southwest Blvd. P.O. Box 1067 Jefferson City, MO 65102 (314) 635-6811

STATEMENT TO THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE COMMITTEE ON FINANCE
ON
CAPITAL FINANCING UNDER MEDICARE
March 9, 1984
Gordon H. Butler, Administrator
Memorial Community Hospital
Jefferson City, Missouri

Mr. Chairman and members of the committee, I am Gordon Butler, administrator of Memorial Community Hospital in Jefferson City, Missouri. Our hospital has 91 beds and is located in rural Missouri in a community of 35,000.

As a result of legislation and regulation already in place, we have reduced our Medicare average length of stay from 7.60 to 6.79 from 1983 to 1984. Medicare discharges for our hospital also have leveled off during this time. This is a positive indicator that we are striving to live within the restraints of the new reimbursement system, modify our internal behavior and work with our medical staff members to change their practices.

Distortion in operating costs among hospitals exists in any system that is based on a payment system which is not institution-specific. Managing under a payment system based primarily on averages will be a major challenge for hospitals. Though distortion in operating cost will present challenges to hospitals, that distortion is minor to the differences which exist among hospitals regarding capital related costs. In Missouri, capital related expenses compared to total operating expenses range from approximately 2 percent to 26 percent. The reasons behind this difference can be attributed to a number of factors, including age of facility, amount of current indebtedness, differences in current capital financial arrangements, size of operation, patient services, age of patient population, location of other facilities and operational limitations.

An averaging method for reimbursement of capital related expenses will certainly be detrimental to health care unless recognition is given to the current financial obligations of hospitals. These obligations are normally incurred for an extended period of time. An adequate transitional period must be established to reimburse hospitals until their current capital obligations are met.

The current Medicare prospective payment system will not reduce the health care needs of the elderly or the demands they make on physicians and hospitals as patients. With no incentives for other providers and the patients, a hospital is at risk financially for the elderly population is serves. In adopting prospective payment for hospitals, Congress has taken a major step to change incentives. All Medicare patients and all Medicare providers, including physicians, nursing homes and other facilities, should be at risk. Congress's action has put the full burden of savings in the Medicare program on hospitals. Attention must be given for placing all providers, as well as the Medicare patient, at risk financially in the utilization of health care services. This must be done to balance the demand and supply equation of health care with available financial resources.

I appreciate the opportunity of speaking to you today and will entertain any questions you may have.

STATEMENT OF CHARLES O'BRIAN, ADMINISTRATOR, GEORGETOWN UNIVERSITY HOSPITAL, WASHINGTON, DC

Mr. O'BRIAN. I think that using averages is a real danger here, and it depends on the life cycle of a particular institution. Many of the teaching hospitals are quite old, and those that are contemplating replacement, for example, I think are looking at fixed asset costs for their replacement facilities of a quite high nature. But that only occurs maybe every 50 years or 30 years, and so, taken as a life cycle, for all the institutions I think you probably will find that the averages appear to be lower than the real need.

I think another factor that ought to be considered is the current method of capital financing as it relates to its impact on operations. Many of the Council of Teaching Hospitals are State institutions and, as States have been pressed not only for operating funds or subsidies for the teaching programs, they have also often had the same problem with the capital. And so there has been, I think, a deferral particularly in this period of high interest rates in many instances of facilities that are going to be replaced, and I suspect in the future there is going to be a substantial need for some of those replacements.

To get back a minute to the methods and the impacts which the current methods have, our institution has used a variety of methods. In older times, we were able to work through the Hill-Burton Program and other Federal programs, and that, of course, is nonexistent any more. So, most of our capital financing has come from either our own internal equity that we have been able to build up and put back into the institution, to which I might add that current medicare and any cost-based reimbursement system really does not contribute to because medicare and other cost-base systems reflect only historical costs. It does not reflect any future costs or ability to be able to put money from your capital side of your house aside to rebuild.

And I think that that is one of the flaws in the current system in that you don't have—from the capital recognition standpoint and from the operating guidelines prior to prospective payment—any ability to capture substantial funds from cost-based reimbursements.

Senator DURENBERGER. That is what I was trying to get at with Bob Streimer earlier—that if they just use the depreciation measurement for the historical and they just use interest for the future, where does that leave——

Mr. O'BRIAN. Yes; if you built something in 1970 and it cost you $5 million, and if by the year 2000 you have to replace it, and it is going to cost you $50 million, under the cost-base system you can under both operating and capital—now that perhaps will change with prospective payment—but from the operating standpoint and the capital you literally will have to get finance for the whole thing.

Senator DURENBERGER. Do you get penalized in some way for investment income?

Mr. O'BRIAN. Yes; the interest of that investment income gets offset against any depreciation or interest events that you might have from that.

Senator DURENBERGER. I am sorry that I interrupted you.

Mr. O'BRIAN. But that is a good point, and I think it does impact on institutions a lot. A final source of funding for capital is fundraising, and I think on a national basis that has been a fairly insignificant and certainly fairly undependable source of income and, given the size of the field, I don't think it can be really counted on very effectively. We will focus then on debt financing, and I guess there are several points that we would like to make. I think from the vantage point of the health care system that public policy should dictate that capital financing ought to be done on the most economical basis possible, and I think that is an area where concerns in the industry have to be focused on the potential of restriction of use of tax-exempt financing which in fact go to limit the costs of capital, given a project that really should be funded.

And I think many hospitals have used it. In the District, we have a particular problem—in terms of use of taxes in financing—that is tied up with the constitutional issue related to legislative veto, and I am sure you are probably familiar with that particular issue.

But our institution, along with others in the city, is in line for some financing through that mechanism when that problem gets alleviated. Now, I have focused mainly on capital of fixed assets. I think the next area that perhaps should be dealt with is the movable equipment or other technology types of equipment, and again, the cost-base reimbursement does not reflect replacement price, so you again—and under past medicare, medicaid cost-base practices—you have not been able to develop funds to replace that except you totally debt-financed it.

Now, in point of fact, most institutions have tried to gather income from other than medicare, medicaid and other cost-base services, and that, of course, has resulted in the program of cross shifting that has caused concern.

So, I think that from a public policy, that it has almost been encouraged and mandated.

Senator DURENBERGER. OK. You mentioned philanthropy, and that isn't the natural transition for Catholic hospitals, but it just gives me the opportunity to say to everybody I guess—and I don't want to spend a lot of time asking questions about it—but if you compare the hospital industry traditionally with something like higher education, you can clearly see that once we made the decision—either through employers or through medicare and medicaid and what not—to finance everybody as fully as possible—finance everybody's access to the system—philanthropy started to decline. Now, I can either ask you, Chuck, or I will ask the Catholic hospitals and others—I know it hasn't declined totally because I am in the middle of one with my hospital back in Minneapolis, and I am going to do some other things. But there must be some folks who are still getting at philanthropy and others that are not, and as we go through the course of this year, I would hope that all of you involved in the hospital business would think about how we can recreate an interest in the philanthropic side in this whole area. I know it is over there in higher education, and there are a whole lot of companies and a whole lot of foundations and a whole lot of other people now pouring money into saving colleges, some of which probably shouldn't be saved.

So, you are going to take the brunt of this change in the way we pay for things in the system, and you have already been sort of forgotten about by that whole sector.

So, I would appreciate all of you thinking about that a little bit. As you know, I have a strong interest in foundation tax legislation—most of which is oriented toward more foundation giving and charitable giving, rather than less. So, if in that regard we can be helpful to the health care industry, I would certainly like to do it.

I will ask our two witnesses from the Catholic Health Association, John Curley and Sister Geraldine Hoyler to speak now. John.

STATEMENT OF JOHN E. CURLEY, JR., PRESIDENT, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, WASHINGTON, DC

Mr. **Curley**. Thank you, Mr. Chairman. Regrettably, philanthropy isn't as natural a transition to Catholic health care as we would like it to be, and I am sure that Sister Geraldine will have an opportunity to address that question more specifically when we get to the question part of it.

Senator **Durenberger**. It all goes to Notre Dame and St. Mary's in South Bend. [Laughter.]

Mr. **Curley**. That is right. For the record, my name is Jack Curley. I am the president of the Catholic Health Association. Sister Geraldine Hoyler, who joins me this morning, is vice president of finance for the Holy Cross Health System, which is located in South Bend, IN. And we are here today representing more than 630 Catholic hospitals throughout the country.

Our testimony, an extended version of which has been submitted for the record, contains three points that we would like to emphasize this morning. No. 1, the Catholic Health Association subscribes to the notion that there are clear advantages to including capital costs in the medicare prospective payment program. However, CHA's own preliminary studies in this area indicate that however desirable the goal may be, finding a method for accomplishing it equitably may be far more difficult and precarious than many analysts originally thought. My second thought is that it is widely assumed that if Congress does not act quickly to end the capital cost passthrough by including such costs in the DRG price there will be an inevitable explosion in medicare capital payments to hospitals.

The Catholic Health Association believes there is growing evidence that challenges this conventional wisdom, and, Senator, you have already referred to that.

Medicare prospective payment of operating costs in combination with other recent but profound changes in the health care market is beginning to have a moderating effect on hospitals' interest in making additional capital expenditures. That this is occurring should not be surprising as capital—especially equipment—has operating costs associated with its use. Hospitals are, therefore, compelled to factor the medicare predetermined fix rate per case on the operating side into any capital acquisition decision. CHA's actual evidence in this area is as yet anecdotal and limited to a few areas of the country, but the phenomenon seems to be a growing one and needs to be taken into account as Congress examines the feasibility of folding capital into the medicare prospective rate. And I might add, parenthetically, that we, too, are interested in more definition on that issue, and are preparing our own studies and data collection, and would be pleased to make that available to the committee as we proceed.

No. 3, hospitals are also beginning to demonstrate their serious concern about the high cost of capital through capital refinancings as well as through the use of a variety of other vehicles, two of which we are prepared to address this morning—the master trust indenture and the variable rate demand note. And I might note here that the variable rate demand note is totally dependent on the continuing availability of tax-exempt bond financing to not-for-profit hospitals.

Sister Geraldine and I will be happy and pleased to answer any questions you or members of the subcommittee might have. If there are any questions we are unable to answer this morning, then we would be pleased to submit answers later in the interest of assisting the subcommittee. Thank you.

Senator DURENBERGER. Thank you very much. Sister.

[Mr. Curley's prepared statement follows:]

The Catholic Health Association
OF THE UNITED STATES
CHA

1250 CONNECTICUT AVE NW
SUITE 234 • WASHINGTON DC 20036
202 - 296-3993

HOSPITAL CAPITAL FINANCING IN THE CURRENT MEDICARE ENVIRONMENT

Statement Of
The Catholic Health Association Of The United States

Before The
Subcommittee On Health
Of The
Senate Committee On Finance

March 9, 1984

Representing more than 800 hospitals and long-term care facilities nationwide.

NATIONAL OFFICE: 4455 WOODSON ROAD • ST LOUIS MO 63134 • 314 - 427-2500

Mr. Chairman, Members of the Committee:

Good morning. I am John E. Curley, Jr., President of the Catholic Health Association of the United States (CHA). CHA is an association of hospitals and nursing homes sponsored by religious orders and dioceses of the Catholic Church. As a national association it represents 630 member hospitals and 282 long-term care facilities. Joining me this morning is Sister Geraldine Hoyler, CSC, Vice President, Finance, for the Holy Cross Health System, South Bend, Indiana.

CHA appreciates the opportunity to share its views with this panel and by doing so contribute to the discussion of capital financing in the context of the Medicare program.

Our testimony will focus on three areas: First, we will share with you CHA's concerns with respect to modifying the Medicare prospective payment system to cover capital costs. Second, we will make several general observations about the moderating effect Medicare prospective payment on the operating side is beginning to have on hospital capital acquisitions, even though Medicare continues to treat capital on a cost-reimbursement basis. Finally, Mr. Chairman, I would like to draw the Subcommittee's attention to the fact that Catholic hospitals, as well as other nonprofit hospitals, are aggressively attempting to reduce the effect of high interest rates on capital, thereby helping to reduce the cost of capital to the Medicare program.

At the conclusion of my testimony, Mr. Chairman, I and Sister Geraldine will be happy to answer any questions you or members of the Subcommittee might have. If there are any questions we are unable to answer this morning, we will be pleased to submit answers to them later in writing.

Why Is CHA So Concerned About Capital?

CHA subscribes to the view that there are several important advantages for hospitals with respect to including capital costs in the Medicare prospective payment system (PPS). However, we are also greatly concerned over how that might be accomplished. In this regard it is important to note that how well or how poorly a hospital or multi-hospital system would fare under a system that pays capital costs prospectively depends primarily on two things:

- First, how well the hospital does on the operating side under Medicare prospective prices; and,
- Second, where the hospital or hospital system is in the capital cycle.

With respect to the first point, preliminary data from surveys conducted by CHA, using 1982 data, suggest that a significant percentage of CHA member hospitals may be adversely and disproportionately impacted by Medicare prospective payment. This data is preliminary and we have already begun the process of surveying our member hospitals for 1984 cost per discharge data that corresponds in time to the Medicare prospective payment prices. In the meantime, we remain understandably concerned.

Congressional Budget Office (CBO) projections of the impact of PPS on the entire hospital population performed in February 1983 indicated that the system would tend to harm larger hospitals more frequently than smaller ones, and that hospitals in the northeast, the east north-central, west north-central and pacific census regions were more likely to be adversely impacted than hospitals in other parts of the country. Catholic hospitals generally follow the same demographic patterns. That is, they tend to be concentrated in the areas CBO identified as losing under the new payment system and they are significantly larger (275 beds) than the average hospital (100-125 beds). As can be seen from the attached table, higher percentages of Catholic hospitals are concentrated in the higher bed size cells than other subsets of the hospital population.

Not only are Catholic hospitals larger on average, but they account for a higher percentage of advanced high-tech kinds of services. The following table illustrates this point:

Type of Service	Services Rendered By Catholic Hospitals As A Percentage Of Such Services Rendered By The Total Hospital Population*
Burn Care	13.66%
Organ Transplant	14.43%
Open Heart Surgery	20.87%
Neurosurgery	19.11%
Body Scan CT	10.82%
Cardiac	18.98%
Dialysis	17.51%
Radiation Therapy	20.00%

---

* Catholic hospitals represent 10 percent of all nonfederal community hospitals.

The number of services and the extent those services are of an advanced high-tech nature may be a function of size. It should be emphasized in this regard that only 23 to 25 percent of CHA's hospitals are teaching hospitals and eligible for the double teaching adjustment.

Our second point with respect to how a hospital will do under a system of prospectively paid capital centers on the position of Catholic hospitals in the capital cycle. And in this regard, special consideration should be devoted to the recent development of multi-hospital systems and their use of Master Trust Indentures as financing vehicles. In the Catholic hospital environment, multi-hospital organizations are organized along the lines of sponsoring religious orders of sisters. Over the years, the hospitals sponsored by some of the religious groups organized themselves more formally as multi-hospital systems. There are presently 44 Catholic multi-hospital systems. These systems account for 58.6 percent of all Catholic hospitals or 62.3 percent of Catholic hospital beds.

Multi-hospital systems have begun to take advantage of a relatively new financing vehicle, the Master Trust Indenture. This vehicle allows the multi-hospital system to borrow on the strength of the overall corporation. In many instances this results in better interest rates than many of the individual hospitals within the system would otherwise be able to obtain. Because new debt for new capital projects is almost always part of these financings hospitals that are involved in them are at the beginning of their capital cycles.

Capital Financing Under Medicare's Prospective Payment For Operations

It is often suggested in policy circles that a failure to incorporate hospital capital into the Medicare prospective payment system will result in runaway capital spending. However, CHA believes there is a strong probability that the Medicare prospective payment system enacted in the Spring of 1983 will have a strong moderating effect on hospital capital financing. A number of instances already exist in which hospitals, because of the potential or actual impact of PPS, have down-sized capital projects, changed their financing plans for projects underway or ceased making capital expenditures altogether.

Inasmuch as the new payment system is based on national averages, close to one-half of hospitals will initially have Medicare costs per discharge that are higher than the PPS rates. If such hospitals also have a high Medicare patient load, they are likely to be denied access to the capital markets. It should be remembered that 93 percent of a hospital's Medicare revenues will be governed by PPS. Inasmuch as the Medicare payment is based on predetermined payment rates per case, hospital administrators will have a strong incentive to avoid capital projects that either do not reduce operating costs or increase revenues.

Others have argued that during the capital pass-through period hospitals will have an incentive to substitute capital for labor. This would be a valid concern if it weren't for the fact that the overwhelming majority of hospital personnel are involved in direct patient care and therefore not readily susceptible to a capital-for-labor substitution.

In summary, CHA believes that before capital costs are incorporated in the Medicare prospective payment system it is extremely important that Congress and the Administration examine carefully the present and future effect of prospective payment of operating costs on hospital capital expenditures.

Catholic Hospitals Are Aggressively Attacking The High Cost Of Capital

Another criticism often leveled against hospitals is that they will borrow at any rate of interest because under cost-reimbursement for capital interest expense, Medicare will cover all "reasonable" costs, no matter how high the interest.

There is, however, growing evidence that Catholic and other nonprofit hospitals are aggressively attacking large capital costs associated with high interest rates. The remainder of our testimony will deal with two new forms of financing, the Master Trust Indenture and the variable rate demand note, that hospitals are using to obtain lower interest rates and therefore lower capital costs. In fact, hospital use of the variable rate demand note was developed and initiated by Our Lady of the Lake Regional Medical Center, Baton Rouge, Louisiana.

Master Trust Indenture (MTI): Nonprofit multi-hospital systems are moving to Master Trust Indentures (MTIs) very rapidly. This is particularly true of Catholic multi-hospital systems. In 1983, five Catholic multi-hospital systems brought financings to market using the MTI vehicle.

Under an MTI, all the hospitals in a multi-hospital system agree to do their borrowing through the system and MTI vehicle. The individual hospitals in turn pledge their assets to stand behind the financings entered into by the system.

The credit markets look to the financial strength of the overall hospital system. In many instances, this results in credit ratings and rates of interest that are better than individual hospitals could obtain on their own.

When their capital needs arise, each of the individual hospitals within a system does its capital borrowing through the multi-hospital system MTI. The system gains more expertise in structuring financings and the capital markets gain more familiarity with the corporation, resulting in better ratings, better interest rates, and reduced costs to the Medicare program. For some hospitals, participation in an MTI can mean the difference between access to capital and no access.

Because the financial risk associated with a capital financing is diversified over the entire system, a multi-hospital system using an MTI can structure more flexibility into its financing. For instance, when a single hospital finances, it is not unusual for it to have to include in its indenture as a condition of the borrowing some fixed asset such as unused land. This is done to satisfy lenders that there will be assets available to pay off the loan in case of default. Assets included in such covenants cannot be disposed of or encumbered without retiring the debt. However, under an MTI arrangement, risk is diversified over the entire system and individual hospitals are not subject to such restrictive covenants.

Variable Rate Demand Note: This new vehicle allows hospitals access to capital at much lower interest rates than conventional tax-exempt financing, but requires the financing hospital or multi-hospital system to assume more risk.

This vehicle generally works as follows: the hospital or system sells tax-exempt bonds through a tax-exempt issuer such as a state or local financing authority. The bonds will have a maturity of 20 years but the holder can "put" them back to the hospital on the first day of each month or at any time on seven days' notice. Because of the "demand" nature of the bonds the interest rate is usually much lower than prime. Recent tax-exempt variable rate demand notes have been entered into at rates as favorable as 55 percent of prime.

In order to be able to access this financing vehicle a hospital or system must be able to obtain an irrevocable letter or line of credit from a major bank in the amount of the financing. A letter of credit can add annually as much as 1.5 percent of the outstanding debt to the cost of the financing.

Even with the cost of the letter of credit, however, tax-exempt variable rate demand notes can result in substantially lower interest rates than long-term tax-exempt paper. In recent months prime has hovered at 11 percent and long-term tax-exempt paper has been hovering between 10 and 11 percent. A 55 percent of prime variable rate demand note backed by a letter or line of credit at 1.5 percent of the unpaid balance of the loan results in an overall cost of capital of approximately 7.5 percent per annum. Such interest rates are 2-1/2 to 3-1/2 percent lower than those available through conventional tax-exempt financing.

Variable rate demand notes were first used as a vehicle against present inflation rates. Administrators unwilling to pay the current rate of interest went to short-term financing, using variable rate demand notes with a view to entering into a long-range financing when interest rates came down to what they consider more acceptable levels. However, recently some hospitals and systems have entered into variable rate demand financings with a view to using that vehicle over the long-term.

The risk assumed by the hospital or system is in two areas. First, the variable rate demand note fluctuates with the prime rate. Second, these notes are usually placed privately with a small number of buyers. While private placement does reduce the cost of issuing the notes, it increases the chances that a larger number of a hospital's bonds will be "put" back to the hospital or system at any one time. Once the bonds are "put" back to the hospital they are remarketed. The entity that remarkets the notes draws on the letter of credit to pay principal and interest on the notes until they are remarketed. Any monies used under the letter of credit will cost the hospital the prime rate of interest or a rate close to prime.

This kind of financing is not available to every hospital that might want to use it. First, they have to be able to obtain a letter of credit from a bank in the amount of the financing. Second, because a hospital or system that would use this vehicle assumes more risk than under the conventional financing vehicle, this vehicle is only available to those hospitals and systems that can demonstrate above average financial strength.

Summary

- The Catholic Health Association subscribes to the notion that there are clear advantages to including capital costs in the Medicare prospective payment program. However, CHA's own preliminary studies in this area indicate that however desirable the goal may be, finding a method for accomplishing it equitably may be far more difficult and precarious than many analysts originally thought.

- It is widely assumed that if Congress does not act quickly to end the capital cost pass-through by including such costs in the DRG price, there will be an inevitable explosion in Medicare capital payments to hospitals. The Catholic Health Association believes there is growing evidence that challenges this conventional wisdom. Medicare prospective payment of operating costs in combination with other recent but profound changes in the health care market is beginning to have a moderating effect on hospitals' interest in making additional capital expenditures. That this is occurring should not be surprising as capital - especially equipment - has operating costs associated with its use. Hospitals are, therefore, compelled to factor the Medicare predetermined fixed rate per case on the operating side into any capital acquisition decision. CHA's actual evidence in this area is as yet anecdotal and limited to a few areas of the country, but the phenomenon seems to be a growing one, and needs to be taken into account as Congress examines the feasibility of folding capital into the Medicare prospective rate.

- Hospitals are also beginning to demonstrate their serious concern about the high cost of capital through capital refinancings as well as through the use of a variety of other vehicles, two of which we addressed this morning - the Master

> Trust Indenture and the variable rate demand note. And I might note here that the variable rate demand note is totally dependent on the continuing availability of tax-exempt bond financing to not-for-profit hospitals.

In conclusion, Mr. Chairman, the degree of difficulty involved in developing an equitable means of paying hospitals prospectively for their capital, not to mention the critical importance of this issue for the future of Catholic and other hospitals, argues strongly for the use of extreme caution in arriving at any early conclusions with respect to how it should be done. The fact that fiscal pressures on the operating side are causing hospitals to approach new capital acquisitions cautiously, and to do what they can to reduce the cost of existing financings, provides Congress and the hospital community with the time they need to approach the issue with the care it requires and deserves.

Consequently, Mr. Chairman, I want to applaud you for beginning this process early, and assure you of CHA's willingness to work with the Committee and its staff on this important matter.

NUMBER OF HOSPITALS BY BED SIZE BY TYPE OF OWNERSHIP

	Catholic		Not-For-Profit		For-Profit		State And Local		Federal		
Inside SMSA	No. Hosp.	% Of All Catholic	No. Hosp.	% Of All N/P	No. Hosp.	% Of All F/P	No. Hosp.	% Of All S&L	No. Hosp.	% Of All Federal	Total No. Hospitals
6 - 99	14	2.2	388	13.8	308	34.6	212	11.0	57	17.2	979
100 - 199	63	10.1	425	15.1	199	22.4	118	6.1	39	11.8	844
200 - 299	111	17.8	292	10.4	92	10.3	77	4.0	18	5.8	590
300 - 399	90	14.4	214	7.6	25	2.8	48	2.5	22	6.6	399
400 - 499	76	12.2	128	4.5	8	.9	44	2.3	26	7.9	282
500 +	62	9.9	189	6.7	2	.2	65	3.4	53	16.0	371
Subtotal	416	66.6%	1636	58.1%	634	71.3%	564	29.5%	215	65.0%	3465 (52.6%)
Outside SMSA											
6 - 99	101	16.2	745	26.5	191	21.5	1113	57.8	81	24.5	2231
100 - 199	81	13.0	299	10.6	56	6.3	195	10.1	12	3.6	643
200 - 299	20	3.2	92	3.3	8	.0	44	2.3	15	4.5	179
300 - 399	4	.0	32	1.1	0	--	6	--	3	.01	45
400 - 499	2	.0	10	.0	0	--	3	--	3	.01	17
500 +	1	.0	3	.0	0	--	2	--	3	.01	9
Subtotal	209	33.3%	1181	41.9%	255	28.7%	1363	70.7%	116	35.0%	3124 (47.4%)
TOTALS	625		2817		899		1927		331		6589

American Hospital Association
Hospital Statistics, 1981 Edition

STATEMENT OF SISTER GERALDINE HOYLER, VICE PRESIDENT FOR FINANCE, THE HOLY CROSS HEALTH SYSTEM, SOUTH BEND, IN

Sister **Hoyler**. Mr. Chairman, I am vice president for finance of an 11-hospital—multihospital—system located in six States, one of which is Indiana, which is composed of 11 not-for-profit 501C3 hospitals, one hospital-based skilled nursing home, one free-standing skilled nursing home, one congregate living center, and one subsidized elderly handicapped housing. And in the past, we have used a variety of forms of financing, any of which I would be pleased to answer questions about, including traditional taxable mortgage bonds, tax-exempt bonds both with and without mortgages, master trust indenture taxable bonds, and variable rate notes—not demand notes, however.

In relationship to your questions about philanthropy, we have experienced—despite full-time efforts—yet decreasing donations to our institutions. Less than one-half of 1 percent of our gross operating revenue comes from philanthropic sources. This is in part not based on a religious character—because we are obviously a religious hospital sponsored by the Sisters of the Holy Cross—but rather on the perception on the part of many that there are adequate funds available within the system to pay for the needs of hospitals, including care of the indigent—which in our experience is not true—and for future and present ongoing capital needs. The public—no matter how well educated—does not seem to address the issue of philanthropy in responsive methodology.

Senator **Durenberger**. Let me ask this as a general question of the panel. Are there—other than the things that we have talked about in this testimony—instruments of access to capital that are not available to nonprofits that are available to someone else in the system to the disadvantage of nonprofits? Other than, say, the obvious of equity ownership and tax consequences—that exist for the investor-owned facilities. Are there other ways in which the nonprofit hospital organization has been in effect discriminated against in its access to capital?

Mr. **Owen**. I think the equity issue and issuance of stock—I wouldn't say that that is necessarily discriminatory, but it is a different way of financing which is not available to many of our nonprofit institutions. But that is about the only thing I can think of where there is a difference right off the top. I am not sure that I would classify that as discriminatory.

Senator **Durenberger**. No; anybody else from their personal experience?

Mr. **Owen**. I think that Gordon's point about use of bonds without using tax exempt is interesting from the standpoint that there are a number of nonprofit hospitals that go that route and do not use tax-exempt bonds but use regular bonds that are issued, and that is another way to——

Senator **Durenberger**. You have got to be crazy to use taxable bonds, don't you?

Mr. **Owen**. That depends. I think you could cite that at the time he got his bonds that were taxable, they were probably requiring him to pay less than what some of the nontaxables are going for at the present time.

He told me this morning he had something like a 9 percent, or something like that, and I remember——

Mr. **Butler**. It was 9¼, and the rate at that time was quite a bit higher. And the other aspect was the economic situtation—the building project—we saved approximately 15 percent on the project by initiating at that time and using public bonds rather than——

Senator **Durenberger**. When was that time?

Mr. **Butler**. Last year.

Senator **Durenberger**. Last year?

Mr. **Butler**. Yes, sir.

Senator **Durenberger**. I would like to see the case study on that one.

Mr. **Owen**. That is not common though, Senator. We would be hard put if we didn't have the tax-exempt bond financing available to most of our hospitals.

Senator **Durenberger**. We don't have the public hospitals here yet, but I assume there was a time when they had an advantage over everyone else in the general obligation bonds—they had a rate that was quite substantially less than any other rate on the market. But today, since all of you and everybody else—including Burger King and McDonalds and everybody else in that business—it really doesn't seem to me to be any advantage left to them either. I mean, the margin between the cost of a general obligation bond and a tax-exempt bond is so small that that seems to be gone as an advantage to publicly owned facilities.

Did you want to add something, Sister?

Sister **Hoyler**. Who you are and how well you are recognized in the marketplace determines the terms of the financing issue, and obviously, size or name recognition—while not directly translated into dollars—does impact the conditions of the debt which then either ties the institution or frees the institution in an unforeseen future instance to certain activities.

Senator **Durenberger**. All right. Does everybody agree that size is a factor? Gordon sure does.

Mr. **Butler**. Yes.

Senator **Durenberger**. Is there a place at which that cuts—somewhere between——

Mr. **O'Brian**. Most of the rating companies—bond rating companies—have criteria that they look at, including size, percentage of the patient population under medicare—the larger that percentage is——

Senator **Durenberger**. Name recognition was the second one. What is that all about?

Mr. **O'Brian**. Yes.

Senator **Durenberger**. Your town gets money that Holy Cross Sisters don't.

Mr. **O'Brian**. Primarily, within a market area, at least this institution is recognzied as——

Senator **Durenberger**. And the next one is the percentage of medicare——

Mr. **O'Brian**. And medicaid patients. It tends to downgrade. The larger that percentage is—the tendency is that the lower the rating is one of the many criteria. They look at the medical staff composition, age, demographics—are you dependent on one or two or a small number of physicians. All of these are factors that go into a rating, and certainly size is one of those.

Senator DURENBERGER. How about management?

Mr. O'BRIAN. They look at that as well. Usually, one of the added expenses of tax-exempt financing—but it is there—is called financial feasibility—a study that you have to pay for, and one of the rating agencies then looks at all the material, including the operating effectiveness of the institution, how well it collects its debts, what type of patient population it has—all these factors make a determination, and size tends to be a factor. Market share happens to be another factor.

Senator DURENBERGER. Where is debt-equity ratio in all this?

Mr. O'BRIAN. There are criteria, and again, it varies by institution, but they look for that ratio as well. If it is too high—if the equity is too high—they look with concern on that. On the other hand, they look at it if it is too low.

Senator DURENBERGER. You mentioned the whole issue of the uncompensated care, and I know in my home town hospital—run by the Benedectine nuns—they are sitting there with 80,000 population and telling me that they have a mission, and they have to take care of the poor and that the whole community has a mission, so as soon as they walk in the door and if they haven't got the money—well they still get excited. How is that sort of a system going to survive in the kind of direction that we seem to moving here in reimbursing for operating expenses, if one of the penalties in access to capital is your record on uncompensated care?

Sister HOYLER. I believe the issue of uncompensated care is one of the major ones which we have yet to face in the industry. Many community hospitals—both religious and voluntary—accepted Hill-Burton funds, not understanding or not knowing the criteria that would be later attached to them in terms of the methodology assigned by the Hill-Burton program for rendering care under its auspices.

In addition, in many, many locations no State, county, or municipal facility exists, and therefore there is no one to care for those who are underserved or unserved except the community hospitals in that local area. I think it is widely believed by the general public that these people do not exist, that they are all covered by some program. They are not. And since they are not the cost of caring for those persons falls directly to one of two sources one's ability to generate funds from philanthropy for the care of the poor—as we would say—which up until the current regulation would have been offset from the medicare payment, and second, for some other third party payors—the commercial insurances and the Blue Crosses and what few self-pay patients remain. The fact of the matter is that in many States one or more of these third-party carriers will not accept the burden of fully shouldering the cost of uncompensated services, and so, persons who are uncompensated—whose care is uncompensated—and hospitals which are gaining a larger and larger share of this group of persons are finding it extremely difficult under the current environment. There is some hope that with adequate rates in the medicare prospective payment weight that the Federal Government will indeed participate in this program in this mission, but until this point in time there is no evidence of that.

Senator DURENBERGER. We may be able to get more into this issue when we have the rest of the series of our hearings on health care for the economically disadvantaged, but if I am responsible for spending $60 billion a year or whatever I am, I have a little problem with the argument that you need to help me resolve, and it sort of gets back to management skills and some of these other things.

There are people who somehow know how to manage that area called uncompensated care, and there are some who don't necessarily know exactly how to do it. And as that part of it gets larger and larger, it gets harder and harder for me to say, well, if that is a religious-based hospital, that is a good excuse for not sending anybody a bill. I think you can see the difficulty I have in dealing with that issue, but at some point in time, we have to reach some agreement on how we handle that issue.

Mr. OWEN. If I could just comment on that a second, Senator. I think that the problem with it as it relates to capital, I think it is other than a capital issue. It is how to take care of people who need to be taken care of out of a price which is shared in some fashion or through grant funds. Where it runs into difficulty with capital is that where you are trying to amass some capital from those who do pay or from medicare and then have to use those capital funds for operational funds, you are depleting your opportunity to renovate or do something to your plant and that is where many of those hospitals that you cited find themselves getting into very difficult situations because they have no money left then for renovation or doing things to the plant because they have taken care of a community because someone hasn't met their obligation—the community being whatever that community is.

Senator DURENBERGER. Right. OK. Were you going to add something to that?

Sister HOYLER. I was going to say that I think it is very unusual that those patients are not billed. My experience has been that everyone is billed. But I do think that there is a whole population who are not covered by any sort of program, whether private or public program. And these people have a high need for health care.

Senator DURENBERGER. And our problem is to try to figure out the degree to which capital is going to subsidize that or operating is going to subsidize that or something else is going to compensate it. And I guess that is your message as well.

Sister HOYLER. Yes.

Senator DURENBERGER. Thank you all very much. I appreciate your testimony.

Our next witness is Ronald R. Kovener, vice president, Healthcare Financial Management Association, Washington.

Thank you very much for being here, and your full statement will be made part of the record. You may do with it as you please.

STATEMENT OF RONALD R. KOVENER, VICE PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, WASHINGTON, DC

Mr. KOVENER. Thank you. My name is Ronald Kovener. I am vice president of the Healthcare Financial Management Association. I am pleased to represent our 23,000 members. These introductory remarks about capital reflect our association's significant involvement in the subject, and we look forward to a future occasion to recommend specific medicare action with respect to capital.

We would like to take these few seconds to point out that capital is not a single issue but a collection of issues. And therefore, HFMA believes that the multifaceted nature of hospital financial operations, including capital, indicate that capital is not amenable to any simplistic single-focused payment arrangement. I will list a few examples of the many attributes of capital. More detail is included in our written submission.

Hospital prices paid by medicare under the prospective payment system are not established through market forces, and therefore hospital capital formation and management is not analogous to that of other businesses. Capital involves long-term commitments and those commitments have been influenced by past Government policies, such as the Hill-Burton program, the medicare and medicaid programs, Federal tax measures, and various control programs. There are also various types of capital, such as equipment, buildings, and working capital, each with its own characteristics.

Terminology and financial information about capital is prepared from different perspectives. Accounting terms and concepts can be different from economic terms and concepts. Sources of capital also vary, including profit, philanthropy, taxes, and stock. We would like to emphasize that all hospitals, including those that are tax exempt, have owners who are responsible for the hospital's capital. Capital costs as a proportion of total costs are influenced by many factors, including the location of the facility and the types of services provided. These are a number of attributes of capital that illustrate the multifaceted nature of the subject. We believe that the recently enacted PPS program is causing massive changes in the field and that capital decisions are being influenced by PPS even if no changes are made in the way medicare pays for hospital capital-related costs. While capital is a small portion of overall cost, it is essential, multifaceted, and not appropriately satisfied by a simplistic single-focused medicare prospective payment arrangement.

I would be happy to answer any questions.

[Mr. Kovener's prepared statement follows:]

Healthcare Financial Management Association
Testimony on Hospital Capital Financing
Under the Medicare Prospective Price Setting (PPS) System
before
Senate Finance Committee/Subcommittee on Health
for delivery on March 9, 1984

- **Capital is essential, multifaceted and not appropriately satisfied by a simplistic, single-focused Medicare PPS payment arrangement.**

Good Morning. My name is Ronald Kovener. I am Vice President of the Healthcare Financial Management Association (HFMA). I am pleased to be here representing the 23,000 members of HFMA who include representatives from all major types of hospitals; urban and rural, large and small, investor-owned and tax-exempt, teaching and nonteaching, freestanding and multiple facility. In addition, our membership includes public accountants, financial consultants and investment bankers, as well as representatives of Blue Cross, commercial insurors and others who pay for healthcare services. Accordingly, our members are deeply involved in all aspects of the issue before this committee today. HFMA has devoted substantial time and energy studying capital management in hospitals and other healthcare organizations resulting in a variety of books, monographs and analytical reports. Our monthly magazine, Healthcare Financial Management, has included more than 60 articles on this topic within the last four years. In addition, many of our educational programs have dealt with capital issues. HFMA's large and diverse membership appreciates this opportunity to provide some introductory remarks about capital from the perspective of our association's significant involvement in the subject. We look forward to a future occasion to recommend specific Medicare action. We would like to take these seconds to point out that capital is not a single issue, but a collection of issues. HFMA believes that the multifaceted nature of hospital financial operations, including capital, require careful deliberation and indicate that capital is not amenable to any simplistic, single-focused payment arrangement. Capital encompasses a "set of decisions regarding assets, financing and other resources that either enhance, preserve, or erode the capital value entrusted to the organization by investors, be they stockholders, a religious organization, government or a local community."*

---

* Silvers, J.B., and Unger, W.J. (eds), Capital Management in Healthcare Organizations: Investment and Financing Strategies (Oak Brook, IL: Healthcare Financial Management Association, 1983), page 150.

Hospital prices paid by Medicare under PPS are not established through market forces and, therefore, hospital capital formation and management is not analogous to that of other businesses. Prices established through market forces can reflect the differing financial responsibilities of various payors. Medicare pays hospitals an administered price -- not a market price. In the absence of a mechanism for establishing a Medicare market price, such as through beneficiary payments, special care is required to insure an equitable flow of capital to hospitals.

Capital involves long-term commitments and those commitments have been influenced by government policy. For example, the Hill-Burton program provided $4 billion in grants and loans for hospital construction. The Medicare and Medicaid programs initially encouraged hospitals to expand their capacity to meet a significantly increased demand for inpatient services. Federal tax measures have played a role in hospitals' access to capital markets and decision making, including tax deductions to donors of philanthropic gifts, the availability of tax-exempt municipal bonds, and for a taxable hospital, the availability of investment tax credits and accelerated depreciation. Government controls on capital decisions -- such as certificate-of-need and 1122 programs, as well as state rate-setting programs -- have also influenced capital decisions.

There are also several types of capital. Equipment, one form of capital, is purchased and turned over continuously, offers opportunities for interchanging capital and labor, involves relatively short-range commitments and is often financed by internally generated funds. Buildings, in contrast, cannot be relocated or converted to other use, are acquired infrequently, involve long-term commitments, and usually are financed in large part with borrowed or other external funds. A hospital must also have adequate working capital -- funds invested in receivables, inventories and other current needs. Working capital needs grow steadily and are customarily financed with internally generated funds.

Terminology and financial information about capital is prepared from different perspectives. For example, depreciation and debt repayment are different perspectives on capital. Depreciation is an accounting allocation of the cost of an asset over an asset's useful life. Depreciation has been the basis of Medicare payment and is the accounting element that enters into the determination of any organization's profit or loss. Depreciation relates to past transactions and events, whereas debt repayment is dependent on future cash flows.

Sources of capital also vary. All organizations need the capacity to create capital by having an excess of revenues over expenses. Borrowed capital is also used by hospitals of all ownership types with tax-exempt hospitals having greater access to tax-exempt financing. Philanthropy is a diminishing source of capital, available only to tax-exempt hospitals. Taxes are a source of capital for government hospitals and, of course, stock is a reliable and growing source of capital for investor-owned hospitals. Owners of all hospitals expect and deserve a return of and a *return on capital. We would like to emphasize that all* hospitals, including those that are tax-exempt, have owners.

Capital cost, as a proportion of total cost, is influenced by many factors, including location and the type of service provided. For example, an x-ray machine, which has an essentially constant cost in whatever hospital it is used, has a different percentage relationship to the cost of labor, food or energy cost in different hospitals. Similarily, a procedure or DRG that requires use of an x-ray machine has a different capital component than a procedure that requires no such equipment.

We have enumerated several attributes of capital that illustrate the multifaceted nature of this subject. The recently enacted Medicare PPS program -- which HFMA supports -- is causing massive changes in the hospital field. For the most part, hospitals are responding favorably to this new federal initiative. Hospitals are working to reduce their operating expenses and enhance their productivity, efficiency and effectiveness. Capital decisions are being influenced by PPS, even if no changes are made in the way Medicare pays for hospital capital-related costs. The flow of funds to hospitals for capital cannot be distinguished from that for operations. The aggregate funding from all sources must be adequate. While capital is a small portion of overall cost, it is essential, multifaceted and not appropriately satisfied by a simplistic, single-focused Medicare PPS payment arrangement.

R. R. Kovener, Vice President
Healthcare Financial Management Association
1050 17th Street, N.W., Suite 510
Washington, D.C. 20036
202/296-2920

Senator **Durenberger**. Oh, I thought you were going to take a little while. Let me start out with somewhere near where I left the last panel—on what are the factors that vary the cost of capital among various institutions.

And let me ask your opinion about the factors that they testified to which included size of the institution, name recognition, uncompensated populations, and a variety of other things which you probably heard me talk about.

Mr. **Kovener**. Certainly. The access to capital is influenced very largely by the institution's ability to generate profit. Profit is, of course, itself a source of capital, and it helps assure that other sources of capital—equity, debt—would be available to the institution. So, the institution's ability to generate a profit is very, very important to its access to capital.

One of the very important influences on a hospital's ability to generate a profit is the amount of charity service that it is called upon to provide, which I believe is in large part a function of location more than management—which you alluded to—and to the proportion of medicare and particularly medicaid patients that the facility serves. Those payment programs do not appropriately compensate for charity care and maybe some of the other costs of providing services to their beneficiaries. As a result, the profit of the institution suffers.

Senator **Durenberger**. Now, I want to get this clear. Do you make the argument, then, that we ought to use the capital system to continue to subsidize the access of the poor and the other economically dependent——

Mr. **Kovener**. The two subjects are very different. It is preferable that we deal with capital as a very separate and distinct subject from the funding of services to the poor. But, capital access is influenced by profit, and profit is influenced by the proportion of charity services that an institution provides. So, there is a linkage, but I think the two are amenable to separate solutions, and they should be.

Senator **Durenberger**. Why did you say it is more of an issue of location than management, when I touched on that?

Mr. **Kovener**. The hospital that is in an inner city location, in a poor part of town, is going to be called upon to provide charity services and no amount of good management in that institution is going to avoid that reality. The hospital that is located in the suburban, affluent area is going to have very little call for charity service, and no matter how poor the management of that institution, they are just not going to have much call for charity. So, location is probably a much bigger determinant of the amount of charity, rather than some managerial control of the amount of charity.

Senator **Durenberger**. I can understand the point as it relates to location and as location relates to populations traditionally being served, but if you take an inner city hospital of 400 beds in a city of 2 million people and compare that with another inner city hospital of 400 beds in a population of 2 million and assuming the demographics are comparable, wouldn't you say that management could make a difference in the cost of that care?

Mr. **Kovener**. Oh, very definitely. Some hospitals feel that a part of their mission is to provide charity service. Others feel that is not part of their mission. To the extent that there is one hospital that is willing and another that would rather not, management is going to have an influence on the way in which services are provided to patients if there is an option.

Senator **Durenberger**. But isn't there an additional factor which is the skill of management? There is a difference between the poor walking into the emergency room of a 400-bed hospital with an aching back and walking into another much less expensive facility because the management of that hospital decided to put it in place in that same general neighborhood. Now, that is a management skill to me, and it seems to me that whoever is selling money out there ought to recognize and to compensate in some way.

Mr. **Kovener**. I think that you are saying that if one hospital can provide an appendectomy for a cost of *x* dollars and another can provide a similar appendectomy for a lower cost, and that is a result of management skill, the charity patient who goes to the less expensive hospital certainly has less charity. Yes, I think that is certainly accurate. There are many, many factors that go into determining how much that appendectomy is going to cost.

Senator **Durenberger**. And I am just curious to know whether or not the sellers of money have demonstrated the capability of distinguishing on the basis of those kinds of proven management skills between one hospital and another?

Mr. **Kovener**. I would say that those people that provide access to debt and equity funds would be looking much more at the bottom line of the operation without a great deal of analysis as to the way the bottom line is achieved. They want to see that there is the capability of future repayment. As long as a hospital can demonstrate that there is a capability, they will have greater access. A hospital is much more apt to be able to demonstrate financial capability if they have a set of operating circumstances that does not subject them to a lot of charity, medicaid, and medicare patients.

Senator **Durenberger**. So, for the foreseeable future, then, the rich are going to get richer, and the poor are going to get poorer, when we look at the hospital landscape.

Mr. **Kovener**. As long as the system is not artificially modified, yes.

Senator **Durenberger**. Are there debt instruments or other kinds of financing instruments out there today that are available to certain kinds of institutions, but not other kinds of institutions?

Mr. **Kovener**. There was some discussion of access to tax-exempt borrowing. There is a difference in access to tax-exempt financing between investor-owned and tax-exempt institutions. Investor-owned hospitals have some limited access but it is certainly not as general. The difference in rate and the conditions for tax-exempt borrowings is really not so advantageous in today's market as it once was. Mr. Butler was mentioning the circumstances surrounding the debt—the various conditions that the loan puts on the operations of the hospital—the ability of the hospital to refinance the debt at a future time—the access to the money and promptness of access—those are all things that enter into the decision. Very often, taxable instruments will be more amenable to being more promptly available and the conditions will be less onerous, and therefore would be more attractive even to tax-exempt enterprises.

Senator DURENBERGER. If we look around the country, are we going to find substantially different lending terms for tax exempts in one community from another—one State from another? Is that an issue we ought to be exploring?

Mr. KOVENER. Strictly on the basis of region or——

Senator DURENBERGER. I don't know. That is why I am asking you.

Mr. KOVENER. I am not aware that that is a significant determinant.

Senator DURENBERGER. All right. There are not restrictions on the borrower that differ from one State to another or from one community to another?

Mr. KOVENER. Oh, I think there may be—as was also mentioned this morning—in the District there are certain limitations that make it difficult. I am sure that there are some of those around the country. I am not familiar with the details.

Senator DURENBERGER. One question that I have some difficulty phrasing appropriately—so I hope I can get my point across—is the whole issue of efficiency in the use of capital. I don't know whether you can help me define that term, but as you listen to the person from HCFA outline reimbursement for depreciation and interest and insurance and taxes and so forth, there really wasn't, in that testimony, any evidence of the way in which that money that was going into insurance or into debt service and so forth was actually being applied. Is there anything in the current reimbursement system that could be changed that would reflect a greater efficiency in the use of capital? There was some testimony here, I think from Chuck O'Brian, about the failure of the system to recognize invested earnings—in fact, it penalizes the income from invested earnings and, in effect, forces the system to go out on the market periodically to borrow. Am I getting my question across?

Mr. KOVENER. It is important to have a system that fosters good, sound management decisions. There is good evidence that, even in the absence of incentives over the history of the medicare program, prudent management decisions have been made. The Catholic Health Association testimony pointed out that indebtedness has been refinanced to secure a lower interest rate, even though the medicare program doesn't really offer any particular incentives to make that kind of a transaction. Management has recognized that lower interest benefits the community and it is the fulfillment of managerial responsibilities. The thing that we need to look to is a system that grants as much latitude of action to managers and rewards good, sound management decisions. If we try to specify each "i" dot and "t" cross and try to figure out exactly how that is going to be done, that may be a little bit more detailed than would really be productive.

Senator DURENBERGER. Yes. Thank you very much, Mr. Kovener. I appreciate your testimony and your written testimony as well.

Our next panel consists of Michael D. Bromberg, executive director of the Federation of American Hospitals; Keith Weikel, president of the Federation of American Hospitals and group vice president of the American Medical International; Merlin DuVal, president of the Associated Health Systems in Phoenix, AZ; William Nelson, vice president for finance, Intermountain Health Care, Salt

Lake City, UT; and Robert Sillen, administrator, Santa Clara County Medical Center in San Jose, CA on behalf of the National Association of Public Hospitals.

Gentlemen, thank you all very much for being here today. Most of you, I think, have statements that will be made part of the record, and we will start in the order that you were introduced. Mr. Bromberg.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, WASHINGTON, DC

Mr. BROMBERG. Thank you, Mr. Chairman. Let me start by saying that we appreciate this opportunity because it is unusual to testify when there is a bill not pending or where we are told not to give specific proposals, and I think that it is a good idea, and we commend you for it.

I am just going to make a few points, a couple of which were not included in our testimony and reiterate one or two that were. One is that on the level playing field issue that it is true that we can accept—we the investor-owned hospitals—can accept a philanthropic gift, but not too many people make them since we are not 501C3's and they are not tax deductible if they do, and while there is some limited use of industrial development bonds, it has become so limited lately—with not only a $10 million cap but with the cost of construction—that it is hard to build even a 50-bed hospital under that $10 million ceiling, and therefore, the use of industrial bonds by our industry has become very limited. There is also some pending legislation which would put another cap on parent corporations which would make it even less likely that we would use it. On the access issue, I would like to reiterate what a couple of previous witnesses have said because I think that it is a lot more important than a lot of the other issues and that is that the access to capital for any hospital for-profit or nonprofit ultimately is going to depend on whether they can show the chance of making a surplus or a profit. That is going to be the critical factor in the future. It has not been in the past because, with interest—a cost-reimbursed item—it didn't matter as much. Now, with being put at risk, it is going to become the key factor, we believe, and therefore, the ability to achieve capital in many ways is going to be related to the adequacy of the DRG price on the operating side.

And cuts and ratcheting down of that price could have more of an impact on capital than what you eventually actually do about including capital. The age of the facility issue—we would reiterate what we heard this morning—that it is a key factor, and I would just add one final point, and that is that in considering what the capital needs are in the future—which will be important in determining at what level you set capital payment—it is important to note that 40 percent of all the hospital beds in America were built in the 1950's and in the early 1960's many of them under the Hill-Burton program, but what that means is that they are all becoming 30 and 35 years of age, a period in which they are going to need major renovation.

So, there is a capital need out there. There is some argument as to what the exact number is, but we wanted to state for the record the cause of that need.

Dr. Keith Weikel, who is with me, is not only our immediate past president but a group vice president of American Medical International, and I hope you will understand and Keith will make it clear that in our industry decisions on capital are made perhaps at a different level of the structure than in others because, ultimately, the decision on whether to spend capital and how to spend it is made in the home office in a multifacility system that is investor-owned.

Senator **Durenberger**. OK. Thank you, Dr. Weikel.

STATEMENT OF M. KEITH WEIKEL, PH.D., VICE CHAIRMAN OF THE BOARD, FEDERATION OF AMERICAN HOSPITALS, GROUP VICE PRESIDENT, AMERICAN MEDICAL INTERNATIONAL, McLEAN, VA

Dr. **Weikel**. Thank you, Mr. Chairman. Just to build on the point that Mike started, I think when we look at a capital investor in the investor-owned industry, we are first of all concerned with what are the needs in the marketplace. What is competition that presently exists there doing in terms of that specific service or that specific capital investment. What the need in terms of the population. What would be the demand for the service or piece of capital and what the utilization rates would be. And determine then whether we can provide that service on a profitable basis to that community at the appropriate level of quality. But that decision is not made at the individual institution. In our own system, for example, no hospital administrator has authority to spend more than $5,000 in capital, and then it would go to our regional office. And the regional office has authority to spend up to $30,000 in capital. And anything over $30,000 has to be determined by the executive committee of the corporation.

So, in a sense, we have built in our own control system for the expenditures of capital that does tend to hold down the types of capital expenditure that you might get if we didn't have controls, if we didn't have criteria for investment. The other point I would make is in terms of the question of the type of capital. Obviously, we have used all the variety of sources of capital to finance our capital projects. Overall, in our own corporation, it is pretty common within the industry for all of our capital—we are looking at 46 percent debt—and about 54 percent from equity. So, you are really looking pretty much at a 50-50 debt-to-equity ratio—pretty close to that.

And I think in looking at the whole question of what type of capital you are going to allow and how you are going to finance it, you need to look at the question of the cost of the capital obviously. And we can operate under any system that you provide fundamentally. You tell us. It costs us approximately 7 to 8 percent for equity, and right now it is costing us anywhere from 10 to 12 percent for debt.

So however you want us to operate, I think we are capable in our management structure of providing that type of capital, but there is a different cost associated with it. The reason equity capital in our situation is less expensive is that investors are willing to make the investment knowing that we are going to invest a significant amount of the profit that is left over into new facilities, into new equipment, to upgrading services. Approximately 75 percent in our own case of the profits are reinvested in terms of retained earnings. Twenty-five percent goes to the investors in the form of dividends. But the reason investors are willing to continue to invest at a lower rate of return is because they think we are able to build the value of our assets through that reinvestment. And I think that is important to them—that is why we can use equity at a lower rate.

Senator DURENBERGER. Thank you. Dr. DuVal.

[The prepared statement of Mr. Bromberg and Dr. Weikel follows:]

STATEMENT OF

MICHAEL D. BROMBERG
EXECUTIVE DIRECTOR
AND
M. KEITH WEIKEL, Ph. D.
VICE CHAIRMAN OF THE BOARD
FEDERATION OF AMERICAN HOSPITALS

SUMMARY

1. There is no rush to implement a new Medicare prospective payment system for capital. Short term continuation of Medicare cost based reimbursement for hospital capital will not touch off a spending boom. Medicare payments per case by diagnosis are fixed so hospitals will avoid higher capital spending that generates higher operating costs.
2. If hospital investment and working capital needs - conservatively estimated at $112 billion and $36 billion respectively - are to be met, hospitals must be able to generate adequate permanent equity capital. The ability to raise debt capital is limited by the size of a hospital's equity base.
3. Tax subsidies have lowered the cost of not-for-profit debt. However, many hospitals are reaching the limit of their debt carrying capacity and will have to increase their equity base. Greater competition and payor cost consciousness are putting pressure on profit margins, the internal source of equity. The traditional sources of external equity - philanthropy and government grants - have declined dramatically.
4. Investor-owned hospitals, who can raise equity in the stock markets, are an important source of permanent equity capital for the hospital system. Their access to

external capital, however, will be curtailed if they are unable to provide a competitive rate of return.

5. Because investor-owned hospitals must pay taxes, cannot accept philanthropy, and cannot issue tax-free debt except in certain highly limited circumstances, they are at a cost disadvantage relative to not-for-profit hospitals, all other things equal. Historically, this operating cost disadvantage has been offset partially by Medicare return on equity payments and the ability of investor-owned hospitals to defer the payment of tax liabilities. Both of these offsets are diminishing.

6. Unless the Medicare capital payment system recognizes the extra burden investor-owned hospitals carry in the form of taxes, they will not have an equal opportunity to compete.

7. Similarly, new hospitals whose capital costs as a percent of operating costs are unavoidably higher than average should not be penalized for decisions they cannot reverse. Accordingly, Medicare in the future should pay for capital in a way that gives new hospitals reasonable opportunity to adapt to a new payment system.

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,100 hospitals with over 135,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on capital financing under the Medicare program.

There is No Need for Precipitate Action

Part of the sense of urgency to replace cost based payment for capital has come from concern that the continuation of the status quo would set off a capital spending boom. This fear is greatly exaggerated. We believe the Medicare prospective payment system enacted last year will restrain capital expenditures beyond the expectations of many policy analysts. The reason is that while capital costs (depreciation, interest and return on equity) are excluded from Medicare's DRG rates, the operating costs associated with new capital expenditures are not.

If, for example, a hospital purchases a Nuclear Magnetic Resonance (NMR) machine for $2 million, it will receive

Medicare cost reimbursement for the depreciation and interest, but no cost reimbursement for the technician hired to run the machine, or the maintenance costs associated with the new service. Unlike the old cost based reimbursement system, a hospital adding a new service such as a burn unit or a coronary care unit will recover capital costs but receive no direct reimbursement for the personnel hired to staff these units. Since every dollar of capital spending produces about 22 cents of annual operating costs on average, the absence of assured reimbursement for capital-related operating costs will act as a very real impediment to capital expenditures, especially new, high cost technology. To illustrate, the ratio of operating costs to capital costs for coronary care units ranges from 1.2 to 3.8; ultrasound from .7 to 1.3 (1). Simply put, the new Medicare DRG prospective payment system which limits hospital reimbursement to a set payment per case by diagnosis regardless of what type or amount of services the hospital provides a patient, has for the first time placed hospitals directly at risk for increased costs due to both operating and capital-related decisions.

---

(1) Arthur D. Little, "Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs," Department of Health and Human Services, Office of the Assistant Secretary for Health, Contract Number 233-79-4003, April 1982.

Some of these capital-generated operating costs would normally be recovered under an intensity index, but the Medicare prospective payment rates in the early years will increase only by one percentage point above the market basket rather than the four percentage points average annual intensity increase over the past decade. Since new capital spending generates higher operating costs, but Medicare's payment for operating costs is fixed by diagnosis, there is little incentive to invest in cost increasing technology. These new operating cost restraints which reward cost efficient behavior by hospitals through incentive payments, are sufficiently strong so that hospitals will not find it in their interest to expand high cost acute care capacity. There is a strong incentive to invest in cost reducing technology and this is precisely what is desired.

Furthermore, since capital costs are only 7 percent of Medicare reimbursement, even a large increase in capital investment by hospitals far beyond any reasonable expectation would have only a minor impact on overall reimbursement. More importantly, since the 93% of Medicare reimbursement going for operating costs is now controlled through the DRG prospective payment system, the remaining 7% attributable to capital costs has been and will continue to be restrained. Since the status quo would not generate perverse behavior, and since capital costs vary so widely among hospitals, we do not think that there should be a rush to implement a new Medicare capital payment system prior to October 1, 1986.

Future Hospital Capital Needs are Large.

Ironically, concern over how to prevent too much hospital capital spending may be exactly the opposite of the real issue. Estimates vary widely, depending on assumptions as to construction costs, inflation, and how much less hospital capital investment is needed if the trend toward outpatient care runs its full course. But there is a consensus that total hospital capital needs in the 80's are large and can be deferred but not eliminated if Americans are to continue receiving the quality of hospital care they have come to expect. It may well be that Congress has already gone too far in restraining capital and that in a short period of time, witnesses will be testifying before you about the lack of capital needed to maintain quality hospital services and the need to revise Medicare prospective payment rates to recognize the real costs of capital, including increased operating costs. The middle case estimate for hospital plant and equipment requirements, 1981-1990, is $112 billion. (2) This figure does not include the capital required to finance higher accounts receivables and inventories. Additional working capital requirements - the difference between current assets and current liabilities - are estimated to be between $36 billion and $39 billion over the same period. (3) The major reason for this large capital need is that about 40 percent of all U.S. hospital beds were built in the 1950's and early 1960's during the prime of the Hill-Burton program. Those beds are now at or nearing an age of thirty years and need major renovation.

---

(2) ICF, Inc., "Assessment of Recent Estimates of Hospital Capital Requirements," Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Contract Number: HHS-100-82-0077, June 1983, p. 24.

There is a Good Possibility of a Capital Shortfall.

It is an open question whether the aggregate capital need for hospitals can be met. One study, (4) conducted before the changes in the Medicare payment system, estimated a cumulative unmet hospital capital need of $54 billion by 1990. This figure in current dollar terms is greater than the total amount spent on hospital construction in the 1970's. Failure to address the capital problems of hospitals could mean that by 1990 about 18% of the nation's community hospital beds - 200,000 beds - would need renovation or replacement but would not have been renovated or replaced for lack of capital.

The Key to Adequate Total Capital is an Adequate Equity Base.

What will determine whether the capital supplied is adequate and whether it will be put to the uses society values the most? The key to raising adequate capital is a sound base of permanent capital. Before a hospital can borrow money, it has to show the lender that it has a base of permanent capital large enough to assure that even if the hospital experiences unexpectedly poor revenues, there is still enough money to pay interest and meet principal repayment obligations, finance innovation and provide working capital.

---

(3) ibid, p. 17.

(4) Harold M. Ting and John D. Valiante, "Future Capital Needs of Community Hospitals," Health Affairs, Vol. 1, No. 3, Hope Foundation, Millwood, VA, Summer, 1982.

The technical term for permanent capital is equity. Investor-owned hospitals and not-for-profit hospitals have the same internal source of equity - profits or surplus.

For-Profit and Not-For-Profit Hospitals Have Different Sources of External Equity Capital.

For-profit and not-for-profit hospitals have very different sources of equity. Investor-owned hospitals can raise outside capital in the equity markets. We estimate that for-profit hospitals have raised over $2 billion in equity capital from outside investors.

The external sources of equity for not-for-profit hospitals have been running dry just at a time when the need is increasing. Historically, not-for-profits have relied on gifts, philanthropy, and government grants - none of which investor-owned hospitals are allowed to receive. Before World War II, philanthropy provided about two-thirds of hospital capital. The

Hill-Burton program, enacted in 1946, provided about $4 billion in government grants to nearly 4,000 hospitals before it was converted to a loan guarantee program in 1970.

During the 70's, the flow of permanent capital to not-for-profit hospitals slowed from a flood to a trickle. For example, from 1973 through 1981, annual government grants for hospital construction declined from $635 million in 1973 to $521 million in 1981 ($274 million in 1973 dollars). Annual philanthropy for hospital construction showed an even steeper decline from $302 million to $168 million ($88 million in 1973 dollars). (5) To offset these declines, many not-for-profit hospitals radically increased their long term debt, primarily tax exempt bonds, as a percent of total capitalization.

Investor-owned hospitals by virtue of their promise to pay investors a competitive return have access to an asset that will soon be in short supply in the hospital field for the foreseeable future - equity capital. If this ability to earn a fair return for people who have supplied their capital is impaired, new capital will not be available. Since investor-owned hospitals have been a major force in bringing new technology and better medical care to areas of the country that haven't had it before, a narrowing of geographic disparities in the quality and sophistication of care depends importantly on continued access to equity capital.

---

(5) Source: Federation of American Hospitals, based on data from "Trends in Capital in the Hospital Industry," prepared by Maureen Metz of the American Hospital Association, revised March 1, 1983, p. 7.

Investor-Owned Hospitals Are at an Operating Cost Disadvantage, All Other Things Equal.

Contrary to widespread misperception, investor-owned hospitals are at a disadvantage in forming equity capital internally. Because they pay taxes, cannot accept philanthropy, and have the same charity and bad-debt loads as comparable private not-for-profit hospitals, the same hospital would earn less income as a for-profit than as a not-for-profit entity. The same hospital would earn half as much profit if it were investor-owned than if it were operating under not-for-profit status (Attachment A).

Prior to the passage of the Social Security amendments of 1983, this income statement disadvantage was partially offset by two factors. First, Medicare's allowed rate of return on equity was 50% higher than at present. Second, investor-owned hospitals have been able to defer but not eliminate payment of tax liabilities through using the accelerated depreciation provisions of the tax law. Two additional points should be noted. First, since 1970 Medicare has reimbursed only on the basis of straight line depreciation. Second, the ratio of taxes actually paid to income subject to tax for investor-owned hospitals - about 36% - is just about identical to that for all corporations.

The ability of investor-owned hospitals to offset their inherent income statement disadvantage is rapidly diminishing. Medicare's return on equity payment has been cut; and, as annual additions to a hospital system's asset base either through acquisition or new construction decline relative to the total size of the asset base, actual tax payments will more closely approximate tax liabilities. Consequently, if Medicare's prospective payment system for capital did not include an allowance for return on equity to investor-owned hospitals and there were no consideration for the fact that investor-owned hospitals pay taxes, they would be at a severe disadvantage regardless of the excellence of their managements.

Do Acquisitions Give Us an Unfair Advantage?

There has been some objection to the practice whereby Medicare pays a hospital a higher depreciation allowance if its assets are purchased by another hospital at more than the selling hospital's historical cost. For example, if an asset costs a hospital $100 but another hospital pays $200 for the same asset, Medicare's depreciation allowance is based on the cost of the asset to the purchaser, not to exceed fair market value, rather than the original cost.

Several important aspects of this issue should be noted. First, this practice is not specific to investor-owned hospitals. Not-for-profit hospitals follow exactly the same practice when making acquisitions. Second, in paying a higher depreciation allowance, Medicare is doing nothing more than paying the purchasing organization on the basis of its cost basis. Parenthetically, simple arithmetic will show that it is not in an acquiring hospital's interest to inflate the purchase price in order to obtain a higher depreciation allowance. A one dollar increase in the purchase price of an asset would generate only a few pennies extra Medicare payment. Furthermore, if disposition of a depreciable asset results in a gain, an adjustment is made in the provider's allowable cost. Third, government feels perfectly justified in collecting capital gains and higher property taxes when appraised market values rise or basing Hill-Burton grant paybacks after acquisitions on current market value. It does not seem consistent to object when higher market values cause it to make slightly higher Medicare payments. Fourth, if Medicare eventually abandons cost based reimbursement for capital, the whole issue of the merits of higher depreciation allowances resulting from hospital acquisitions will become moot.

The Level Playing Field Principle Requires an Age Adjustment.

We have argued that it would not be in the public interest for the Medicare payment system to discriminate arbitrarily against hospitals that pay taxes. Implicit in this argument is the idea that the payment system should promote equal opportunity among private hospitals. The equal opportunity principle should apply also to the problem of how to pay new hospitals whose capital costs are above average. Unlike decisions pertaining to operating costs such as staffing levels and supplies, managements cannot reverse past decisions to build a hospital, and any capital payment system should recognize the legitimacy of these higher costs and give newer hospitals adequate time to adapt.

Summary

In summary, if the hospital sector is to have adequate capital and if that capital is to be used efficiently, a Medicare prospective payment system must be fair. The Federation of American Hospitals pledges its cooperation to the Department and Congress in efforts to develop a capital prospective rate because we continue to believe that Medicare payments should be totally prospective. A fair Medicare price will restrain all hospital costs, including capital, but an arbitrarily low price will reduce capital spending below what consumers and communities expect in modern hospital technology.

ATTACHMENT A

Changes In A Hospital's Income Statement IF It Switched From For-Profit To Not-For-Profit Status (Based on Aggregate 1981 Income Statement For Investor-Owned Acute Care General Hospitals)

	For-Profit		Not-For-Profit	
	$(000)	%	$(000)	%
Gross Patient Revenue	10,451	100	10,451	100
Deductions From Revenue				
• bad debt, charity other (1)	413	4.0	413	4.0
• contractual allowances				
--before Medicare ROE	1,682	16.1	1,711 (2)	16.4
--ROE (3)	108	1.0	--	--
--net contractuals	1,574	15.0	1,711	16.4
• Total deductions	1,987	19.0	2,124	20.4
Other Revenue				
• miscellaneous, e.g., cafeteria income	139	1.3	139	1.3
• philanthropy, gifts (4)	--	--	84	.8
• Total	139	1.3	223	2.1
Expenses				
• payroll and employee benefits	3,704	35.5	3,704	35.5
• services & supplies	3,370	32.2	3,370	32.2
• depreciation	315	3.0	315	3.0
• interest (5)	328	3.1	246	2.3
• Total expenses	7,717	73.8	7,635	73.0
Income Before Taxes	886	8.5	915	8.7
Taxes	457 (6)	4.4		
• property	58	.6		
• other (excluding payroll)	82	.8		
• federal income tax	317	3.0		
Net Income	429	4.1	915	8.7

Assumptions

1. There is no difference in charity and bad debt loads between the two types of hospitals. According to data from the American Hospital Association, charity and bad debt for private not-for-profit hospitals amounted to 4.0% of gross patient revenues in 1981.

2. Since Medicare pays its pro rata share of property taxes (based on the ratio of Medicare costs to total), contractual allowances for the investor-owned hospital are less than they would otherwise be by that amount. Thus, if the same hosptial had NFP status, it would pay no property tax, but at the same time, its contractual allowance would be higher since Medicare was not reimbursing its pro rata share. For purposes of increasing the NFP contractuals, we assumed that Medicare and Medicaid's share of total days (50%) was roughly the same as its share of total costs. This overstates the increase in NFP contractuals somewhat since costs are usually less than days.

3. Assumes reduction to 1 X the rate received by the Health Insurance Trust Fund.

4. AHA's best estimate of philanthropy is 1.4 percent of net patient revenues, or 1.1 percent of gross patient revenues.

5. The interest rate spread between taxable and tax-exempt bonds is estimated at 25 percent. This is lower than the spread estimated by Treasury and CBO computing revenue losses for the average difference between taxable and non-taxable bonds over the period 1972 through 1981. The spread was based on a comparison of 20 year bonds with the same rating.

6. The tax rate shown includes property taxes (.6 percent of gross patient revenues), state, and other taxes (.8 percent of gross patient revenues), as well as federal taxes (3.3 percent of gross patient revenues, or 37 percent of pre-tax income).

Revised 2/29/84

STATEMENT OF MERLIN K. DuVAL, M.D., PRESIDENT, ASSOCIATED HEALTH SYSTEMS, PHOENIX, AZ

Dr. DuVal. Thank you. Mr. Chairman, I would like to join the others in thanking you for the privilege of being with you today. We have written an introductory statement and have filed it, and I will not read it this morning.

By virtue of the fact that the Associated Health Systems is a new entity, I would like to make just a brief introductory comment. We represent 12 of the Nation's largest voluntarily not-for-profit multihospital systems. We own, lease or manage 178 hospitals with revenues in excess of $3 billion.

For us as nonprofit institutions, the issue is how to make available a full range of services to all of those who need it at a time of constrained resources. We do this through the creation of systems. We share services. We try to reduce costs through economies of scale and central purchasing. We try to formulate capital through achieving greater size and when possible by pledging assets or revenues, and spreading the losses from uncompensated care across several different institutions. We do this because we believe that in this current situation we face in the United States we are better off in the marketplace than in a regulated society. We believe that wholeheartedly. We believe that regulation has failed dismally, and has seriously distorted the marketplace and greatly escalated costs. We have no interest in operating in a regulated environment. Rather, we strongly prefer the marketplace and, by virtue of that, it is our position that if competition in the marketplace is to work, we have to preserve access to capital. That will be the position from which we will speak today—and Mr. Nelson from Intermountain Health Care and I—will respond to any questions.

Senator Durenberger. Thank you. Bill, do you want to add any comments?

[The prepared statement of Dr. DuVal follows:]

Statement of the Associated Health Systems

Merlin K. DuVal, M.D.
President and Chief Executive Officer
Associated Health Systems

Mr. Chairman, I am Merlin K. DuVal, M.D., President and Chief Executive Officer of the Associated Health Systems, an association of twelve of the nation's largest non-profit, multi-institutional health care systems. The members of this Association own, operate, or manage 164 acute care non-profit hospitals with over $3 billion in annual revenues.

As non-profit institutions, our hospitals have a history of community service, and of health care to the poor. For some of our hospitals, such as those in the Holy Cross System, such service is seen as a "mission" essential to the very identity of the institutions. For all of our members, such service is seen as appropriate to our non-profit status.

As members of systems, our hospitals seek to strengthen their position in the current market for health services. Our systems encourage cost savings through economies of scale and the use of shared services. They allow us to use the security of our combined size to negotiate lower interest rates on loans. They allow us to "average-out" the heavy burden of uncompensated care in some of our localities over the diverse hospitals in our systems. Finally, our systems have increasingly enabled our hospitals to see themselves as parts of "health systems," not just hospital systems.

We are moving to offer health services in the least costly settings that medical technology permits consistent with quality.

In recent years, Mr. Chairman, as price competition in the health care field has increased, we have found that non-profit institutions with strong senses of mission must be especially efficient and price competitive. We live in an age when government and private purchasers of health care are demanding lower prices, and are less and less willing to help finance our missions. Our systems are striving to perform their community services and still offer competitive prices in the marketplace.

This is a delicate balance, and nowhere is it more apparent than in the area of capital acquisition. If a health care system cannot generate or raise the capital it needs to modernize and grow, it will be unable to follow our Nation's shifting population into areas that are growing; it will be unable to restructure its services in areas that are shrinking in population; it will be outmoded technologically--and ultimately, it will die. To generate capital, or to raise it through borrowing or investment, a health care institution must have a positive operating margin.

Mr. Chairman, our systems are choosing to compete in the marketplace to achieve their margins and their futures. We do not want government regulatory relief. This is a risky and uncharted path in health care, and some institutions and some people may be hurt. But we believe the last 10-15 years show we pay too high a price for regulation that ultimately does not work. As you know, we have suggested that Medicare be moved to a voucher system, an even more market-oriented approach than the DRG system.

Medicare's capital payment provisions and federal tax laws are critical to allowing us and others to compete constructively in the marketplace. If our changing institutions cannot obtain capital, it will take more both in dollars and in the quality of care we receive.

We are pleased at the opportunity to review with the Subcommittee how hospitals in our systems presently obtain capital and how mission and marketplace can be kept in delicate balance.

STATEMENT OF WILLIAM NELSON, VICE PRESIDENT FOR FINANCE, INTERMOUNTAIN HEALTH CARE, SALT LAKE CITY, UT

Mr. NELSON. I have nothing specific except to say that Intermountain Health Care is a multihospital system representing about 25 hospitals. We have borrowed about six times over the last 8 years—used tax-exempt financing for each of those borrowings. And in several of the borrowings, an aspect that may not have been spoken of earlier is that we borrowed for rural hospitals using the strength of our system. If those rural hospitals had had to access the debt market on their own, our understanding from the underwriters was that they would not have had the opportunity of accessing the debt market had they had to stand on their own reserves. So, there is a real strength in the multihospital system.

Senator DURENBERGER. Thank you.

I am aware of what you are talking about. Maybe for the record, it would be appropriate for you to describe at least those four hospitals and the kind of market that Intermountain is serving in those rural areas.

Mr. NELSON. Intermountain Health Care has hospitals located throughout the State of Utah and southeastern Idaho. The majority of that area is rural—farming and very small business kinds of activities. Over half of our hospitals are located in those rural areas. A little town—Logan, UT, for example—we just built a replacement—a brandnew hospital—and had that community had to borrow on its own, it would not have found funds available simply because that facility, small as it is and subject as it is to the whims of the economy—would probably not by itself have been a sound enough investment that investors would have been willing to put money into it.

Senator DURENBERGER. When you say small, what are we talking about?

Mr. NELSON. A 70-bed hospital.

Senator DURENBERGER. Seventy?

Mr. NELSON. Yes. But when as a system we can provide the financial strength of the group of 25 hospitals, then that borrowing becomes more attractive. And I think that is a critical element that becomes available through the development of these not-for-profit multihospital systems.

We can pool resources, spread risk if you will, within communities, and really provide a number of services, not the least of which is accessing the capital markets, either at a significantly lower cost or being able to do that at all.

And I guess I would just underscore what Mr. Bromberg said. I believe that more critical to access to debt, at least in the future, is what happens to the level of payment for operating expenses so that it is demonstrable whether or not repayment can be made on debt than specifically what happens to the debt component, which is really a very small component of overall operating costs in a hospital.

Senator DURENBERGER. Thank you. Bob.

STATEMENT OF ROBERT SILLEN, ADMINISTRATOR, SANTA CLARA COUNTY MEDICAL CENTER, SAN JOSE, CA

Mr. SILLEN. Thank you, Mr. Chairman. It is a pleasure for me to appear before you today on behalf of the National Association of Public Hospitals, the California Association of Public Hospitals, and my own institution, Santa Clara County Medical Center. I think it not inappropriate that the public hospitals bring up the rear in today's testimony. We are getting very adept at viewing the world from that perspective, and our problems are relatively intimately related with that position in life. Given the earlier testimony this morning and your questioning of it, quite frankly I am going to change what I was originally going to talk about and just respond primarily to your questions, which I think are hitting many nails on the head.

And so, rather than bore you with listening to me, I will reduce my testimony, and just make what I think are a couple of essential points. One is that operating revenue and capital reimbursement policy cannot be unattached, as far as I am concerned and as far as public hospitals are concerned. I think we heard earlier from Mr. Bromberg—or it might have been Mr. Weikel—that bottom line is the primary determinant of access to the capital market. And when one has a patient mix like my institution's—76 percent either MediCal—that is California's strange version of medicaid—medicare or unsponsored patients, with the last category being 21 percent of that 76 percent, there is no access to the capital market. There is no bottom line for us, only negatives.

The good side of our balance sheet—in terms of debt and equity, and so forth—is that we have no debt. The bad side is that that is because we can't borrow. [Laughter.]

So, we have no debt, and we also have no equity. Public hospitals, and especially public hospitals in California, are significantly older and more fully depreciated than any other sector of the hospital industry.

So, I think that one cannot detach operating costs from capital, the ability to generate profits or operating margins in the nonprofit and public sector, in terms of paying for one's own capital or in terms of gaining access to almost any kind of capital market.

You mentioned earlier, I think, that general obligation bonds are a thing of the past. That is probably momentary. I think they will probably have to come back. I hope they do, but if one is familiar with proposition 13 in California, one shudders to think of getting a two-thirds vote of any local electorate.

The jails are overflowing. There are constitutional suits. Prisoners are being released, and the electorate will not vote to build new jails. That puts me at a slight disadvantage in terms of the electorate for taking care of poor people in whom most of the electorate have no stake and most of whom—that is the poor people—don't vote in the first place.

Public hospitals obviously are political issues, and the resolution is going to be a political resolution because you as a politician and I as a public policy implementer—I am government, you are government, my board of supervisors is government—we are the ones who are going to be held accountable in the end if poor people cannot get care.

Now, that brings me to my second point, regarding competition. Nobody is competing for my patients. I have 24 percent private-pay patients. They are all in tertiary services. They are in neonatal intensive care units. They are in my burn unit—the only one in the entire bay area south of San Francisco. They are in my spinal cord rehab unit, one of only 17 recognized by the Federal Government over the years. All the high-cost, very specialized services in my institution, and they are there because we are a teaching hospital. We are affiliated with Stanford. We have the house staff. We have around-the-clock physicians. We have all the costs associated with that, and we are the providers of that care. Without us, that care is not delivered in San Jose. It is costly, but it is also needed by our private-pay population. The other 76 percent—ain't nobody competing with me. You mentioned management before. The private hospital administrators are managing their uncompensated care very effectively. They send them to me.

Now, some of that is not entirely inappropriate—some of those patients need to come to me because I am the only game in town that can provides certain levels of trauma and the other services I mentioned before. On the other hand, maps are being handed out. Directions are being given. Cabs are being utilized in order to get unsponsored patients and poor people from their hospitals to my hospital.

Now, it is not as though the private sector does not meet a very basic and public policy need in terms of providing uncompensated care. The private sector does meet that, and I would be the last to say that they don't do anything in that regard. Without them, we would all be under—I can guarantee that. But some of the data is a little bit startling. In California, there are only 31 public hospitals left—county hospitals. Now, this does not include the University of California teaching hospitals. I don't consider them public. Sometimes they don't consider themselves public, but in any case, they do not share what in California is the mandated safety net responsibility. The county hospitals have that responsibility, and so the university hospitals are not included in this data.

Senator **Durenberger**. There are three of your five that are going broke because they aren't doing what other hospitals are doing by way of dumping, or transferring, or——

Mr. **Sillen**. That is absolutely correct, and as a matter of fact, I came from a university hospital in California to the county hospital. I don't know if that is out of the frying pan into the fire, but you are absolutely right. And that would even skew this data even more.

Thirty-one hospitals constitute 7 percent of the acute care hospitals in the State of California. We 31 county hospitals account for 48 percent of the charity and bad-debt care; 31 hospitals account for 48. So, the private hospitals have, in fact, the majority of such care—52 percent. But they constitute 93 percent of the hospitals. Something is disproportionate in that, and not being a statistician, I am not sure what it is, but clearly 31 hospitals providing 48 percent means there are disproportionate providers.

I would imagine if one took the University of California data out and included it on the public hospitals side, then that would add another 10 to 15 or 18 percent of the bad-debt and charity care. So, in any case, the only point I am trying to make is that nobody is competing for the patients who can't pay and for the poor people, and the severely sick—the truly sick—elderly. One of the problems is that my institution has 14 percent medicare right now, and quite frankly, it isn't my biggest headache, because I have 40 percent MediCal. Now, if MediCal gets any more severe in California, we are going to have all sorts of problems. I mean, we already have all sorts of problems, but in relation to unsponsored patients and MediCal and medicare—which is obviously a small part of my pie—I would be willing, if I were a betting person, to bet that over the next 3 or 4 years under DRG's, my medicare census is going to increase because my medicare census is what is called medicare-MediCal crossover. It is the poor medicare patient—it is not the good medicare patients—it is the sick and the poor medicare patients, and as soon as everybody figures out what are the profitable versus unprofitable DRG's, the unprofitable one is coming to me, if I can take them.

Now, obviously, we will look back with some hindsight and see whether or not I am crazy or whether or not I am a good prognosticator. In any case, it is certainly possible. So, there is no level playing field out there. And this basically involves three areas: One is service mix. We, the public hospitals, are disproportionate providers of the costly services and the unreimbursed and underreimbursed services; 60 percent of the outpatient care in California is provided by the 31 public hospitals. Seven percent of the hospitals provide 60 percent of the services in outpatient care. Well, there is no magic to that. Every MediCal patient you serve, you lose—it is hard to make it up in volume. You just drive yourself deeper into debt, to say nothing of the unsponsored patients. Second is reimbursement mix. Not only do we have the sickest of the sick and the poorest of the poor—we don't get paid for them at anywhere near what could be assumed to be cost. California last year had a major MediCal transition—transferred responsibility for 265,000 former MediCal recipients to the counties, and for the honor of taking care of 100 percent of them, they transferred 70 percent of the dollars they thought they would have spent otherwise, and there is no further increase in this year's budget.

I mention MediCal because it is not unrelated to what is going on in medicare. So, it all comes back to roost here in one form or another.

We have the adverse service mix. We have the adverse reimbursement mix, and there is no level playing field. Because of those two things primarily.

Third, our capital needs far surpass those of anybody in the private sector, and we have supplied data to show our old and depreciated assets, which require access to the capital market.

When I went to my institution in 1979, it had started a master facilities plan process in 1977. For various reasons, not the least of which was proposition 13 in 1978 when GO bonds became effectively a thing of the past, it has been delayed and delayed and delayed. It went from a $94 million project to a $200 million project. I have now had to cut it back to a $45 million project because last year the fire marshal came in and closed down half of our psychiatric facility because it is an absolute danger to patients.

I think I will stop there.

Senator DURENBERGER. Thank you.

[Mr. Sillen's prepared statement follows:]

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1775 Pennsylvania Avenue, N.W., Washington, D.C. 20006 (202) 862-1090

Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey Hospital (Newark)
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
Glades General Hospital (Belle Glade, Florida)
Los Angeles County U.S.C. Medical Center
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
City of Memphis Hospital
Seattle Public Health Hospital
Los Angeles County King/Drew Medical Center
University of New Mexico Hospital
Harborview Medical Center University of Washington
Fresno County Valley Medical Center
Wayne County General Hospital
Los Angeles County Harbor/UCLA Medical Center
St. Louis City Hospital
General Hospital, Ventura County
R.E. Thomason General Hospital (El Paso)
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)

STATEMENT OF ROBERT SILLEN
Executive Director
Santa Clara County Valley Medical Center

Subcommittee on Health
Committee on Finance
United States Senate
March 9, 1984

Mr. Chairman, members of the Committee, I am Robert Sillen, Executive Director of the Santa Clara County Valley Medical Center, a public teaching hospital serving the residents of Santa Clara County, California. I appear before you today on behalf of my own institution as well as the National Association of Public Hospitals and the California Association of Public Hospitals, of which we are a member. I am accompanied this morning by Larry S. Gage, President of the National Association of Public Hospitals. On behalf of the 50 hospitals and hospital systems which comprise the membership of NAPH, we thank you for this opportunity to testify on the subject of hospital capital finance. There is perhaps no single health policy issue more vital to our nation's public hospitals than capital. And as long as we continue to tolerate huge gaps in health insurance coverage -- gaps through which an increasing number of Americans are falling each year -- the capital needs of public hospitals must be considered a vital national priority as well.

I would like to accomplish four things in my prepared testimony this morning:

First, I will bring the committee up to date on the current situation of public hospitals nationally, including new data comparing the fiscal, demographic and health services delivery situation of metropolitan area public hospitals with other types of hospitals in those areas.

Second, I will review the plight of California's public hospitals, as they confront what is clearly a growing trend in the health industry toward competition, entrepreneurism and the "bottom line" fiscal mentality in health care delivery and financing. We believe this trend creates an extremely unhealthy situation for hospitals serving those patients for whom no private hospital wants or intends to "compete". We have provided you with considerable new data to illustrate the distinct economic disadvantage to California's public hospitals from the incredibly uneven playing field which results.

Third, by way of providing you with one concrete illustration of these problems and issues, I will describe the specific situation of my own institution, in the context of these significant recent changes in the California health system.

Fourth, I will provide you with observations and comments from the public hospital perspective on the various capital financing issues that you will be considering over the next several months --

including some of the reimbursement, planning and tax-related issues raised in the staff paper submitted to us earlier this week.

I. The Situation of Public Hospitals in America Today

A. General Overview

NAPH has described our nation's public hospital system in considerable detail in previous testimony before this Committee. However, we have not appeared before this Committee in several months; I therefore believe it is appropriate in the context of this hearing to describe in some detail what we see as the greatly increased peril to our nation's health safety net from current reimbursement trends; reemphasize several key elements common to America's "safety net" hospitals; and direct your attention to a number of new studies which shed further light on the role and situation of public hospitals in our nation today. As public policy makers rush to find solutions to the crisis in health care financing, increasingly we hear of the need to make hospitals more business-like. We are involved in and witnessing a process whereby hospitals are being converted from charitable, social institutions to economic business ventures guided by the principles of profit and loss. We hear the jargon and buzzwords of the proponents of private enterprise-"market-share," "competition," "efficiency," "bottom line," and "let market forces determine the face of the American health care system."

We in public hospitals see a far different picture of what this will mean to tens of millions of Americans. For as the private hospital industry gears up to compete for the shrinking health care dollar and as their success is measured by size of their profits or operating margins, we must realize that no one will be competing for the majority of public hospitals' patients.

No one will be competing for the indigent patient who cannot pay.

No one will be competing for the Medicare patient who happens to fall into an unprofitable DRG or has multiple high cost health and social problems.

No one will be competing to provide unprofitable tertiary care and regional services such as burn care, trauma centers, emergency alcoholism and psychiatric care, to name only a few. These services will remain economic losers especially if one is "burdened" by a mandate to provide care regardless of patients' ability to pay. What responsible business person would maintain a product line of such economic losers?

No, public hospitals won't have to worry about competing for these patients. They'll come to us because we'll be the only hospital in town that will serve them.

The simple fact is that providing health care to the poor is bad business. Yet, providing health care for the poor is the business of the nations' public hospitals.

Today, America is returning rapidly to a two class system of health care -- one composed of private providers competing for insured, generally healthy individuals and the other consisting primarily of the network of public (and a few private) hospitals serving the needs of the indigent and severely ill who have no access to mainstream medical care. All of this is being done in the name of cost reduction, competition and private entrepreneurial spirit.

But rather than spending our time bemoaning this trend, I believe we must accept it -- for today -- as a fact of our national life. For low income patients, there simply is no level playing field. Moreover, there never has been and in all likelihood, at least in our lifetime, never will be.

In order for public hospitals to live in this new world, there must be an explicit recognition of these changes and recognition of the critical role of public hospitals. Measures must be taken to safeguard our survival and, therefore, access to health care for the nation's poor. In addition, we believe the sweeping changes in medicare reimbursement -- from DRGs to the extraction of a much higher out of pocket cost from the beneficiary -- will increasingly require us to serve the elderly as well. My colleagues in the public hospital sector are absolutely convinced that this will occur -- particularly with those Medicare patients likely to be "outliers" in private hospitals, and those who will no longer be able to afford substantially increased premiums, copayments and deductibles. As the private sector makes its business decisions only we, the public hospitals, will, to the extent that we can survive, remain to care for American's most vulnerable populations.

All public hospitals share one common role -- they serve as the institutional "safety net" which provides care to those sick and needy in our society who are denied access through mainstream financing and provider arrangements. This nation has repeatedly considered enacting National Health Insurance. In its place, the nations' network of public hospitals serve as a less costly surrogate -- an inexplicit, poorly recognized acknowledgement that a good proportion of our population -- due to economic circumstances or special health needs -- fall between the cracks of private insurance and private provider practices.

B. The Uneven Playing Field: National Public Hospital Data

With regard to specific national data in support of these observations, NAPH has conducted several new surveys in the last several months, and we have also begun an intensive analysis of data collected by the Urban Institute in a survey of 1700 hospitals. That survey focused on the extent of medical care for the poor and the financial status of hospitals serving the poor. We will be releasing a more comprehensive analysis of this new data in the next several weeks -- perhaps in the context of the series of hearings tentatively announced by this Committee on the subject of uncompensated care. In the meantime, a summary of some of the information we continue to develop is likely to be helpful in understanding the situation of public hospitals today.

1. PUBLIC HOSPITALS CONTINUE TO TAKE ALL PATIENTS -- REGARDLESS OF ABILITY TO PAY.

Where public hospitals exist, they are "de facto" national health insurance today. According to a 1983 NAPH survey, uncompensated care represented an average of 29% of 1982 inpatient days for NAPH member hospitals (or an average of 46,010 uncompensated inpatient days per hospital). 46% of all outpatient/ emergency room visits to NAPH members, on average, were also uncompensated (106,000 uncompensated visits per hospital).

It should be noted that NAPH member hospitals maintained this "open door" while serving as an essential source of care for many insured patients as well, with each hospital averaging over 158,000 inpatient days and over 229,000 outpatient/ emergency room visits by Medicare, Medicaid and privately insured patients.

How does this effort compare with other sectors of the hospital industry? The new AHA/Urban Institute Survey data enables us to compare the relative levels of care to the poor rendered by various categories of hospitals. In Table I, data is presented for hospitals, by ownership and geographical location, indicating relative proportion of charity care, bad debt and Medicaid for 1700 of the nation's hospitals. The Urban Institute believes this data is sufficiently comprehensive to permit extrapolation of these trends to the nation's 5700 acute care hospitals.

Table 1

Hospital Care to the Poor by Ownership and Location

	Total Hospitals	Beds (percent of total)	Total Poor Care		Charity Care		Bad Debt		Medicaid	
			Amount (Mill.)	Percent	Amount (Mill.)	Percent	Amount (Mill.)	Percent	Amount (Mill.)	Percent
Universe	5,719**	971,738 (100%)	14,389.1	100.0	1,849.8	100.0	3,494.3	100.0	9,045.1	100.0
A) 100 largest Cities	973	34.6	7,744.8	53.8	1,163.2	62.9	1,689.1	48.3	4,892.5	54.0
Public	100	5.0	2,499.1	17.4	745.1	40.3	672.9	19.3	1,081.1	12.0
Non-Profit	681	26.6	4,903.3	34.1	416.4	22.5	901.9	25.8	3,585.0	39.6
Proprietary	192	3.0	342.4	2.3	1.7	0.1	114.3	3.3	226.4	2.5
B) Other SMSA*	1,831	39.6	4,793.5	33.3	531.2	38.7	1,214.6	34.6	3,047.8	33.7
Public	366	6.8	1,187.6	8.2	216.7	11.7	332.6	9.5	638.3	7.0
Non-Profit	1,159	28.6	3,098.5	21.5	310.7	16.8	710.1	20.3	3,077.1	23.0
Proprietary	306	4.2	507.4	3.5	3.8	0.2	171.9	4.9	331.8	3.7
C) Non-SMSA	2,915	25.9	1,850.8	12.9	155.4	8.4	590.6	16.9	1,104.7	12.2
Public	1,317	9.5	676.6	4.7	63.0	3.4	261.1	7.5	352.6	3.9
Non-Profit	1,366	14.6	1,064.9	7.4	88.7	4.8	307.1	8.8	669.1	7.4
Proprietary	232	1.7	109.2	0.8	3.7	0.2	22.4	0.6	83.1	0.9

* Standard Metropolitan Statistical Area
** Extrapolated from 1700 hospital sample

SOURCE: NAPH ANALYSIS OF AHA/URBAN INSTITUTE DATA

This table shows that hospitals in the 100 largest metropolitan areas accounted for most of the charity care (63%) and care to Medicaid clients (54%) and almost half of the bad debt (48%) incurred in the nation. However, although public hospitals in those 100 cities represent only 5% of all hospital beds, their level of charity care -- 40.3% -- far exceeded the next highest group -- non-profit hospitals in these cities (22.5%, with over 26% of the hospital beds), whose primary low income patients were Medicaid recipients. Bad debt in public hospitals was, by bed size, proportionately four times greater than in non-profit facilities. In addition, the metropolitan area public hospitals averaged over $10 million each in Medicaid care, compared to an average of $5.3 million for non-profit facilities. Proprietary facilities in large cities provided an insignificant amount of charity care (0.1%) and experienced very little bad debt and Medicaid care (3.3% and 2.5% respectively).

2. PUBLIC HOSPITALS ARE NOT PART OF THE HOSPITAL INFLATION PROBLEM.

NAPH data shows an average annual inflation rate for public hospital budgets of just 9.8% per year between 1976 and 1980, as opposed to 14.7% for the hospital industry as a whole. And in just one state, California, all hospital costs in 1981 increased 17.9%, while public hospital costs increased by just 10.3%, indicating that this historical gap is continuing and may be widening. New data gathered last year indicates preliminarily that this trend is continuing on a national basis as well. We expect to have this data available for the Committee soon.

3. DESPITE THE PERSISTENT WASHINGTON, D.C. MYTH THAT CITIES AND COUNTIES ARE NOT PAYING THEIR WAY, A SUBSTANTIAL PORTION OF THE PUBLIC HOSPITAL BUDGET COMES FROM LOCAL TAX REVENUES.

NAPH data show that 31% of our members' budgets come from local appropriations, as opposed to 22% from Medicaid and 16% from Medicare. These local sources of revenue serve as the primary source of support for the average $29 million in bad debt and charity care rendered at our public hospitals. Of $2.07 billion in total revenues received by just 23 public hospitals in 1980, $709 million were from state and local non-Medicaid appropriations. And while public hospitals serve a large proportion of Medicaid and Medicare patients, there are relatively far fewer privately insured patients to whom costs can be shifted -- just 12%, on average, among NAPH members around the country.

4. THE NON-MEDICAID UNINSURED CASELOAD OF PUBLIC HOSPITALS HAS SUBSTANTIALLY INCREASED IN THE LAST YEAR.

The August 1983 NAPH survey of unemployed and uninsured patients in public hospitals demonstrated that these facilities are now the source of health care for thousands of individuals who had relied on other health services before unemployment. 44% of the unemployed patients surveyed responded that they had not used the public hospitals as a regular source of care before becoming unemployed. Eight hospitals reporting inpatient and outpatient data had a total of 5506 unemployed and uninsured visits or admissions for a seven day period -- an average of 688 per hospital. If this number is projected for the year, these eight institutions alone will experience over 280,000 visits and inpatient days by uninsured and unemployed patients.

The newly unemployed comprise just one part of the increased indigent caseload of public hospitals in metropolitan areas. The problem is substantially exacerbated by reductions in Medicaid eligibility, and inadequate funding for special populations such as illegal aliens and refugees. Moreover, we believe we can also anticipate a significant increase in more severely ill Medicare patients, as private hospitals move to adjust their caseload to maximize reimbursement under the new DRG system.

New NAPH data for 1982 shows that just 17 public hospitals attributed 917,120 inpatient days to bad debt or charity care, or nearly 54,000 per hospital. Expenditures for unreimbursed inpatient care for just 20 of our members totalled $379 million in 1982, or nearly $19 million per hospital.

5. PUBLIC HOSPITALS ARE IMPORTANT PROVIDERS OF PRIMARY AND AMBULATORY CARE TO POOR PERSONS WHO OFTEN HAVE LITTLE OR NO ACCESS TO PRIVATE PHYSICIANS.

NAPH members average almost 106,000 bad debt and charity care outpatient and emergency room visits, representing about 50% of all visits at these facilities. These uncompensated care visits are a primary reason that public hospitals average 1.5-3 times the number of visits to all hospitals in the nation's

100 largest cities. In some states, the proportion is far higher. Atlanta's Grady Memorial Hospital, for example, in 1981 provided 28% of all the outpatient visits to hospitals in the entire state of Georgia. The costs for this care are high -- almost $11 million per NAPH institution.

Public hospitals also experience a far higher average level of admissions through the emergency room (over 41% for public hospitals in metropolitan areas, as compared with 25-33% for large city hospitals in general).

In addition to the great burden of outpatient/ emergency room charity care currently borne by public facilities in our nation's metropolitan areas, the Urban Institute study finds that high volume providers of care to the poor outside the 100 largest cities are reducing emergency room and outpatient hours or staff at a rate approaching twice that pf low volume providers, suggesting that metropolitan public hospitals may have to care for these patients as well.

6. PUBLIC HOSPITALS IN METROPOLITAN AREAS ALSO PROVIDE SPECIALIZED TERTIARY CARE, HEALTH AND OTHER UNIQUE SERVICES.

These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units -- trauma centers -- emergency alcoholism, drug abuse, and child abuse centers -- neonatal intensive care -- poison control units -- to name just a few.

7. PUBLIC HOSPITALS HAVE MANAGED THEIR RESOURCES EFFICIENTLY.

A recent study by Alan Sager, of Brandeis University, indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of hospitals in the nation's 52 largest cities. Moreover, public hospitals have decreased their total number of bed between 1970 and 1980 -- by over 22% -- in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by State and local governmental entities.

In summary, caring for the poor in our nation exacts a high price from our public hospitals -- higher costs, lower compensation and a stressed financial condition. And all of these factors are likely to have a severe impact on the ability of public hospitals to attract sufficient capital to enable them to fill this vital role.

Table 2 uses Urban Institute data to summarize this perilous situation. It compares hospitals in the nation's 100 largest metropolitan areas by their costs, revenue and financial status (as measured by their operating and total margins). Table 2 indicates that all hospitals in metropolitan areas generally averaged nearly $10 or $30 in surplus revenues per inpatient day, depending on whether they were characterized as "high volume" or "low volume" providers of care to the poor.* Public hospitals as a separate group experienced a loss of almost $18 per inpatient day. In addition, their rate of revenue per inpatient day was $12-$20 lower than than average high volume and low volume hospital. (It should be noted that "high volume provider" includes all of the public hospitals in the sample.) This situation is further exacerbated by the fact that the level of inpatient Medicaid payments per recipient inpatient - $1521 - was $230 less than average revenues per patient in high volume providers in general.

Public hospital costs per inpatient day were also $17-$59 higher than high and low volume hospitals in general.

Public hospital losses per outpatient visit were well over twice the rate of losses experienced by high volume providers in general, while low volume providers actually experienced a revenue surplus from outpatient visits.

Charity care and bad debt as a percent of charges averaged 21% for large city public hospitals, almost twice the rate of the average for high volume providers in general. Finally, public hospitals are the only group to show a negative operating margin and a negative total margin -- characteristics indicative of financially stressed facilities.

---

* To compare facilities by their level of care to the poor, the Urban Institute defined high volume providers as those facilities with at least 13.54 percent of gross charges occurring through Medicaid, bad debt and charity care, and low volume providers as devoting 7.54% or less of gross charges to those categories of care.

Table 2

Selected Financial Characteristics of High and Low Volume Providers of Care to the Poor in the Nation's 100 Largest Cities and Public Hospitals in the 100 Largest Cities -- Urban Institute Sample

	Low Volume*	High Volume*	Public Hospitals
Cost per Inpatient Day	$235.14	$277.05	293.93
Revenue per Inpatient Day	264.02	286.93	274.95
Cost per Outpatient Visit	62.93	63.00	69.18
Revenue per Outpatient Visit	70.17	50.95	40.20
Charity Care and Bad Debt as a Percent of Charges	2.87	10.90	21
Surplus per Inpatient Day	28.89	9.88	-17.68
Surplus per Outpatient Visit	7.24	-12.05	-28.40
Operating Margin	3.4	-2.6	-.15
Total Margin	4.67	1.08	-1

*"High volume" providers are all hospitals with at least 13.54 percent of gross charges devoted to Medicaid, bad debt and charity care, while "low volume" providers are those which devoted 7.54% of their charges to those categories.

SOURCE: NAPH ANALYSIS OF AHA/URBAN INSTITUTE DATA

II. The Situation of Public Hospitals in California

The central role of public hospitals takes many forms throughout the country. It is played in some states by university hospitals or city hospitals. In no State, however, is the role as clearly delineated as in California. Section 17000 of the California Welfare and Institutions Code states that:

> "Every county and every City and County shall receive and support all incompetent poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons, are not supported and relieved by their relatives or funds, by their own means, or by state hospitals other state or private institutions."

Perhaps this clearly enunciated role of public hospitals was better understood prior to implementation of MediCal (as Medicaid is known in California) when 65 county hospitals, operating in 49 of the State's 58 counties, represented the only source of care for the State's indigents. Since that time, the public sector financing crises of the 1970's climaxed by the Proposition 13 attack on local government finance, have reduced the ranks of public hospitals to the current 32 acute care public hospitals, operated by 25 counties. Despite the declining numbers, the remaining public hospitals in California represent the largest public system in the country.

A. No Level Playing Field: Public Hospital Service Mix

While the 31 public hospitals in California account for only 7% of all hospitals and 11.9% of total statewide available beds, they provide far more care in certain service categories than their overall proportion of beds would suggest. Table 1 shows the percentage public hospitals provide of statewide total service units by various service categories:

Table 1
Public Hospitals Service Units as
Compared to Statewide Totals

Service Category	% of Total Service Units
Total Daily Hospital Services	12.7%
Medical/Surgical Acute	9.1
Emergency Room	14.0
Pediatric Acute	14.5
Labor and Delivery	14.6
Obstetrics Acute	15.2
Nursery Acute	15.9
Psychiatric Acute	19.4
Coronary Intensive Care	19.9
Rehabilitation Care	24.7
Burn Care	32.3
Clinics	59.2
Psychiatric Emergency Room	70.5

Source: CHFC Aggregate Hospital Data for FY 1981-82.

Detailed examination of these data reveal some important distinctions between public hospitals and their private sector counterparts. For example, while public hospitals provide only 12.7% of the statewide daily hospital service units, they provide 59.2% of statewide total of hospital based clinic visits. Non-profit hospitals, however, which account for almost 16,000 beds or 56% of total available beds, only provide 38% total hospital based clinic visits statewide. In addition to the high percentage of clinic visits, the above table also documents the significant role public hospitals serve in the delivery of burn care, an extremely expensive service which requires a high intensity of nursing care and many ancillary services.

Behind this rough overview are many of the complex distinguishing characteristics of public hospitals. California 's public hospitals deliver 12.7% of total daily hospital services and only 9.1% of less costly and specialized Medical/Surgical Acute services. Why then do they play so predominate and disproportionate a role in clinic, emergency and acute psychiatric, burn, rehabilitation and coronary intensive care services. The answers are not complex. They derive from the special needs of the poor and from a response to deficiencies in private sector interest in providing costly, nonremunerative services. Remember, providing adequate access to the poor is bad business.

B. Are Public Hospital Patients Sicker?

> The preponderance of available information suggests that, on average, public hospital patients are sicker, more frequently have multiple diagnoses and require more costly interventions.

Many studies have shown that in general low income persons, through a combination of inadequate preventive care and a pattern of inattention to health problems due to economic and linguistic barriers, typically present a more complex and acute set of health problems than do employed and covered populations. As a consequence, patients in public hospitals require multiple interventions and a higher intensity of services to address their health problems. In addition, poverty is often accompanied by a higher incidence of social and substance abuse problems, as well as linguistic barriers to care. As a result, public institutions serving these patients must employ a much broader range of health professionals to staff a wide array of medical, interpreter, public health and social support programs in order to address these multifaceted problems.

The newly Diagnostically Related Groups (DRG)-based reimbursement formula for the Medicare Program, as well as the emphasis on price-driven or capped reimbursement approaches for MediCal and other payors, have stimulated heated debate regarding whether, a hospital day or stay in one hospital is commensurate with the services provided in another hospital.

Until a severity measure is developed which better accounts for the wide range in costs within many DRG's, analysis of patient differences will remain imperfect.

One recent study based on a national sample concluded that patients in public hospitals were, in general, no sicker than patients in private hospitals. However the authors did specifically address the problem of records which failed to accurately and completely capture data regarding multiple diagnoses. When data for this study were collected, public hospitals had no incentive to maintain detailed records which captured more than the primary diagnosis and procedure. Consequently, the authors stated that when public hospitals begin to capture such data, the results of the study could be quite different, as more information will be available to assess severity of illness.

Another way to assess current severity among public hospital patients is to identify at the various categories of patients served in public institutions. As seen on Table 1 the skewed service mix of public hospitals, including a preponderance of many costly services, clearly suggests that, on average, public hospitals do deliver a different, more complex and costly level of service.

The impact of public hospitals' important role in meeting the costly specialty care and emergency needs of patients on per diem or per DRG costs has not yet been carefully studied. However, the labor intensive services and costly technologies required in all of these services, along with long lengths of stay particularly for burn and rehab patients, obviously have a major impact on the average cost of care--care which is clearly not comparable to the service mix provided in typical community hospitals.

C. Public Health and Mental Health Services

Because of the special needs of their patient populations and close linkages to other county health programs, public hospitals often serve as the site for extensive public health and mental health services. Public hospitals in California have borne the brunt of service needs for Indochinese and other immigrants whose health problems include diseases heretofore rarely seen in California, as well as complex cultural and linguistic problems which add to the expense of treating these populations. In addition to a major role in delivering psychiatric emergency and inpatient services, public hospitals often serve as a site for focused programs for the poor in alcoholism and drug abuse treatment. Provision of these services, perhaps more than others, has been relegated to public hospitals, because of the unwillingness of the private sector to accommodate these complex needs. Without public hospitals not only the substance abuse problems of this population, but all of their associated health problems, would be poorly met.

Other unique treatment programs include forensic, family planning, long-term TB programs, Hansen's disease programs, poison control, and child abuse and sexual trauma programs. Preventative programs include

TB prevention, refugee screening, and occupational health programs. While special funding sources underwrite some of the costs of many of these programs, they do impose significant uncompensated costs on public institutions.

D. Outpatient Services

> Public hospitals provide the majority of hospital-based outpatient services in the State. This disproportionate role contributes significantly to net county costs because of grossly inadequate Medi-Cal reimbursement for outpatient care and the reliance of county indigents on hospital-based outpatient care.

In response to the needs of county indigents, MediCal, and other sponsored patients who for socioeconomic and other reasons have failed to find accessible outpatient care in the private sector, public hospitals have developed extensive primary care and specialty clinic systems. As noted earlier, public hospitals provide 59.2% of all units of hospital-based outpatient care. The distribution of users of these vital services by payment source are outlined in Table II (as reported in this data set, outpatient visits includes all clinics, ER, home health, referrals, day care, psychiatric ER and regularly scheduled outpatient visits):

TABLE II
Public Hospital Clinic Visits--1981-82

Payor	City/County Hospital Visits	% of Total Visits
MediCal	1,263,442	30%
Medicare	588,490	14
Other (unsponsored)	2,363,297	56
Total	4,215,229	100%

Source: CHFC Data

Table III places the public hospital commitment to outpatient services in the context of total hospital effort in this area. This table highlights the disproportionate share of funds for outpatient services borne by public hospitals:

Table III
Outpatient Expenses as Percentage
of Total Inpatient and Outpatient
Expenses by Hospital Ownership

Hospital	%
County	29.4
District	15.7
Investor	10.9
Non-Profit	14.8

Source: CHFC Aggregate Hospital Data 1981-82

Public hospitals' outpatient expenses are more than twice that of any other class of hospitals. As with most "provider of last resort" functions, the predominate role of public hospitals in outpatient services has developed in response to the failure of the private sector to provide these poorly compensated services.As is well-known, MediCal is particularly penurious in its payments for outpatient care under its Schedule of Maximum Allowances. As a result, many public hospitals experience their greatest losses in this area.

E. Emergency Services

> Public hospital emergency rooms provide a significant proportion of major trauma care. In addition, public hospital emergency rooms provide access to urgent care to populations who lack regular sources of care.

Public hospitals emergency rooms serve many purposes. They are often inappropriately asked to provide primary health care services to county residents who do not have a regular source of care. As provider of last resort, public hospitals address access barriers in the private sector. Patients with complex social or substance abuse problems, those with language barrieres and those who fail to meet the "wallet biopsies" increasingly imposed by private hospital admitting offices and emergency rooms are transferred (or dumped) to public facilities to secure needed urgent and emergency care.

In addition to providing primary care services and urgent and minor emergency care, most public hospitals, particularly the larger institutions, serve their communities across all economic groups as regional trauma services. As noted earlier, California's public hospitals, with 12.5% of beds statewide and with only 12.7% of all daily hospital services, account for 14% of all emergency room services statewide and 70.5% of all psychiatric emergency services. Other statewide data reinforce this picture of a disproportionate public hospital role in provision of emergency care--for 58% of county hospital admissions result from the emergency room, compared to only 27.6% in community hospitals. Maintaining a fully staffed trauma service, capable of marshalling crisis surgical and medical teams at a moments' notice, requires costly stand-by capacity. Consequently, public hospitals have high costs in admitting departments, owing to the 24-hour nature of non-elective admissions and the costs associated with eligibility determinations for a largely indigent population. For example, one CAPH hospital found its costs in this area were almost two and one half times those of neighboring hospitals due to the demands of its active emergency department. Across all California public hospitals, the average direct expense per unit of service for admitting is $35.57, 53% higher than the average costs of $23.23 experienced by all hospitals.

F. The Uneven Table: Public Hospitals' Reimbursement Mix

> In 1980, public hospitals nationwide accounted for 23% of Medicaid financed care to the poor and 43% of charity and bad debt. In California, public hospitals accounted for 33% of Medi-Cal financed inpatient days and 31% of outpatient days paid by Medi-Cal and 48.4% of bad debt and charity care.

In addition to the critical role of public hospitals in meeting community needs for specialized services, the most important and unique mission of public hospitals is the provision of a comprehensive range of services to indigents. Researchers typically assess the amount of indigent health care provided by various institutions by utilizing Medicaid, bad debt, and charity care as measures of indigency. The Urban Institute, in conjunction with the AHA found that 1980, public hospitals nationwide accounted for 23% of all care reimbursed by Medicaid and 43% of care written off either as a bad debt or charity. This study also found that public hospitals devote almost 40% of their resources to the poor while private hospitals devote only 12.5% of their resources to such care. Thus, based on a nationwide sample population, there is clear evidence that the public hospitals are relied upon to provide the majority of care to those with no ability to pay and a significant percentage of care to individuals for whom the government reimburses at a rate below costs.

Comparable data from California show an even more pronounced role for public hospitals in meeting the needs of the poor. Because of the pattern of excessive pricing in the private sector resulting in disproportionately high "contractuals" it is also useful to compare bad debt and charity care. In 1980-81, California's 31 public hospitals (7% of the total hospitals) provided 48% of the total bad debt and charity care statewide. While the statewide bad debt and charity care constituted 4% of gross patient revenue, public bad debt and charity represented 17% of public hospitals gross patient revenue, over four times the statewide average.

Percent of Total Net Revenue by Payor Source and Ownership
1981-82

	Public	District	Non-Profit	Invester
Medicare	19.5	41.1	36.0	35.5
Medi-Cal	45.0	11.0	13.8	11.0
Other	35.5	47.9	49.2	53.5

Medicare

> Medicare historically constitutes a relatively small percentage of California's county hospital's revenue. This pattern is expected to shift with private hospitals' increasing sophistication in identifying and referring patients who will be unprofitable under the new DRG prospective payment system.

Nationwide, Medicare represents approximately 16% of public hospital's patient revenues. On average, California's public hospitals rely on Medicare for 19% of their revenues. This patterns varies significantly among hospitals for Medicare patients range from 8% to a high of 37%. It is expected that the proportion of Medicare patients in many public hospitals is likely to increase in the future under DRG prospective payment guidelines. While the private sector has readily accepted Medicare beneficiaries in the past, economic incentives, particularly to treat some costly patients, are clearly changing. As private hospitals employ new computer-based "case mix management systems" to identify their more "profitable" services or "product lines", the will attempt to shift their service mix and to refer out their "loss leaders". One article noted that under TEFRA, private hospitals will be more likely to refer Medicare patients to public hospitals and according to Moody's, this will serve to lower public hospitals credit rating. (Kontz, Indigent Health Care Hobbles Financing). Consequently, public hospitals will, once again, be expected to expand their "safety net" role in accommodating the needs of Medicare beneficiaries who will increasingly face barriers to private sector care.

Medi-Cal

> In 1982, California's public hospitals received more than one-fourth of State payments for inpatient care to the Medi-Cal

> population and received more than one-third of the total Medi-Cal expenditures for outpatient care.
>
> The losses experienced by these hospitals in meeting Medi-Cal patient needs is reflected in an alarming 62% increase in "contractual allowances from the previous year, bringing public hospitals excess gross charges over revenue to 23%.

California's public hospitals received 27.5% of State payments for inpatient care to the Medi-Cal population in 1982 and 35.5% of expenditures for hospital-based clinic visits. The historical importance of Medi-Cal in public hospitals' revenue base sets public hospitals apart from other hospitals. This percentage has been declining since the late 1970's and the decreasing amount seriously jeopardizes the ability of public hospitals to continue providing the comprehensive range of services to all persons, regardless of their ability to pay. The following table illustrates the historical importance of Medi-Cal in relation to other payors:

Medi-Cal as Percent of Total Revenues

1981-82

	Inpatient	Outpatient	Total
County	37.3%	7.7%	45.0
District	8.9	2.2	11.1
Investor-Owned	9.1	1.9	11.0
Non-Profit	11.6	2.2	13.8

Source: CHFC Data

Obviously the transer of MIAs in mid-FY 1982-83 has impacted the relative importance of sponsored (Medi-Cal) and unsponsored indigents in the workload of public hospitals. However, after correcting for the change in MIA eligibility status, comparison between the first quarters of 1982 and 1983 show there to have been a 9.4% increase in Medi-Cal program expenditures to public hospitals for remaining eligibles. Thus, these figures demonstrate an increasing role for public hospitals in the provision of Medi-Cal services. While the actual number of Medi-Cal beneficiaries may have decreased, those who turn to public hospitals and are eligible for benefits require intensive and costly services, which result in public hospitals receiving an increasing proportion of statewide Medi-Cal program hospital expenditures. While the remaining Medi-Cal revenues may have decreased, they still form a significant proportion of public hospitals' revenue base and are critical to preserving the economies of scale that permit the scope and breadth of services now provided to sponsored and unsponsored indigents alike.

As commonly understood, losses in the private sector from "cost-based" payors such as Medi-Cal have historically been offset by elevated charges to charge-based payors. For seven reporting CAPH hospitals, private insurance constituted only 14.4% of net collections in 1982-83. Therefore, little compensation for Medi-Cal losses can be accomplished through cost-shifting to this small payor group.

While public hospitals rely on the Medi-Cal program to provide, in some cases, up to a third or more of their patient revenue, it should not be assumed that counties are able to generate a surplus from this program. Quite the opposite, public hospitals experience significant losses from their Medi-Cal outpatient efforts and most experience losses from inpatient care as well.

III. SANTA CLARA VALLEY MEDICAL CENTER - A CASE STUDY IN THE DILEMMA FACING PUBLIC HOSPITALS

Santa Clara Valley Medical Center (VMC) is located in the City of San Jose, the most populous city in Santa Clara County, 50 miles South of San Francisco. Home of the famous Silicon Valley high technology industry, it is a prosperous and fast growing county with about 1,300,000 residents that perhaps has been less affected by the recent recession than most counties in the nation. About 8% of the county population is covered by the Medi-Cal program and 7.5% are eligible for Medicare benefits, significantly less than the average for most California counties and the Nation as a whole. In addition to VMC, there are 10 other hospitals dispersed through the County, ranging from the 663 bed Stanford University Hospital in the north to the 46 bed Wheeler Hospital in the rural southern portion of the County. However, even in an affluent county like Santa Clara, the need for a public hospital to meet the needs of the poor that are not met by the private sector is acute and real

Santa Clara Valley Medical Center a 617 licensed acute bed facility was founded in 1860, and is the oldest hospital and only publicly operated hospital in Santa Clara County. Located in the center of the county, it plays a unique and vital role in the local health care delivery system and the Northern California region as a provider of a comprehensive range of acute inpatient services as well as many regional referral tertiary care services unique to the County and region:

Regional Tertiary and Specialty Care Services

- Regional Burn Center
- Nationally recognized Rehabilitation center for traumatic spinal cord and head injury patients
- Pediatric Intensive Care Unit
- Regional Tertiary Neonatal Intensive Care Unit
- Regional Poison Control Center
- Regional High-Risk Pregnancy Program
- Paramedic Base Station Hospital
- One of two hospital providers of chronic renal dialysis services
- Comprehensive Emergency Department

VMC provides an extensive array of ambulatory care services through its network of 60 primary, specialty and sub-specialty care clinics and three primary care satellite clinics located in the eastern, central and southern parts of the County. In FY 1982-83, these clinics provided over 140,000 patient visits and are projected to provide 200,000 visits in FY 83-84. This represents over 33% of all clinic visits in the County, excluding the Kaiser system.

In addition VMC operates the only 24 hour comprehensive emergency service in the County with inhouse capability in all major medical and surgical sub-specialties. In FY 1982-83 the Emergency Department experienced over 52,000 visits, overwhelmingly more than any other hospital in the County and is projected to provide over 65,000 visits in FY 83-84. Over 50% of VMC admissions come through the Emergency Room compared with about 25% in private hospitals..

Major Provider to Low Income Persons

VMC is the major provider of care to Medi-Cal beneficiaries, the medically indigent, and other low income persons in the County. VMC is the highest volume provider of Medi-Cal inpatient services in Santa Clara County and one of the top ten highest providers in the entire state. Over one third of the Medi-Cal population in HFPA 431 depends on VMC for its inpatient services as well as ambulatory care services and VMC is projected to provide almost 40% of all Medi-Cal patient days in the County in FY 83-84.

As a result of its service mission, State and Federally funded programs now account for 55% of VMC's total inpatient population and unsponsored inpatients who look to VMC as the provider of last resort under Section 17000 account for an additional 21%. With such an extremely large portion of public care, 76%, VMC is in no position to cost shift governmental program losses to privately insured patients and depends upon these programs to pay their fair and equitable share of the costs of maintaining VMC services.

PATIENT MIX BY PAYOR CLASS BASED ON PATIENT DAYS

Category	1980-81	1981-82	1982-83	1983-84 Est.
Medi-Cal	45.4%	47.3%	43%	41%
Medicare	23.7%	27.2%	21%	14%
Insurance	23.0%	21.3%	20%	24%
Uninsured	7.9%	4.22%	16%	21%
	100.0%	100.0%	100%	100%

Severity of Illness and Complexity of Care

As a large county hospital with many specialized and regional services, SCVMC serves a much higher proportion of low-income patients with correspondingly more acute and severe health conditions than served by the private hospitals in Santa Clara County. Medicare's DRG analysis of VMC's Medicare population indicated a case mix index of 1.1609. VMC's own commissioned DRG study of the Medi-Cal population indicated that VMC's acuity index was 1.236 relative to the County-wide index of 1.000. Both of these studies indicated that SCVMC serves a more severely ill population than the other community hospitals in the County both in terms of a more complex DRG mix and higher severity of illness within individual DRG's.

Impact of Medi-Cal Changes on VMC

In 1982, the California legislature, faced with a severe budget crisis, made significant changes in the Medi-Cal program and opened the door to provider competition in Medi-Cal and private insurance:

- Over a quarter of a million beneficiaries covered under the State funded Medically Indigent Adult program were eliminated from the Medi-Cal rolls and became the responsiblity of the counties under Section 17000. In return, the counties received about 70% of the State's budgeted funding for this population.
- The Medi-Cal program began selective contracting with individual hospitals for Medi-Cal inpatient services on a competitive, negotiated per diem basis.
- Changes in health insurance codes allowed providers to enter into contractural arrangements with insurance compaines to form preferred provider networks.

Due to these changes, VMC is being caught between an increasing demand for its services and shrinking financial resources.

Where VMC used to receive mostly patient transfers from other hospitals into its regional tertiary units, under the new California competitive environment it has seen a tremendous increase in routine patient transfers for financial reasons as more private providers shun uninsured and Medi-Cal patients. Our average daily census has increased 10% from 1982 to 1983, with the increase attributed almost entirely to uninsured, indigent patients.

Our Emergency Room visits have increased 38% during the last year as private providers refer increasing numbers of indigent and Medi-Cal patients to VMC. Where our E.R. used to see about 130 patients per day of whom 40% were uninsured, it now sees over 180 patients per day of whom almost 60% are uninsured. Clinic visits of uninsured patients has increased almost 200% during this period. In financial terms, VMC provided about 7.5 million in 1982 in services to uninsured, indigent County residents but is projected to provide $34 million in services to these uninsured patients in FY 1984, an increase of 350%. State funding will cover only a portion of this tremendous increase and County support is severely limited due to the continuing effects of Proposition 13.

Very soon we will be forced to decide whether SCVMC can maintain its current levels of service or it will have to cut back and begin to close its "open door." Our experience in California clearly indicates that the emeging competitive model, coupled with shrinking health dollars and capped reimbursement formulas is having dire consequences for public hospitals. Public hospitals are indeed the "safety net" and they are becoming more important than ever before. But their survival is in jeopardy unless policy makers recognize their plight and take measures through responsible reimbursement policies to safeguard them.

VMC'S CAPITAL NEEDS

VMC's physical plant consists of 21 buildings ranging in age from 15 to 75 years old. All of the buildings have numerous deficiencies and code violations caused by their age or obsolete design.

- The main building, 25 years old, has been cited by the State for seismic inadequacy. Only through persistent negotiation has VMC been able to prevent the building from being closed to inpatient use. The State has permitted its continued usage but this does not guarantee its safety. The outmoded design results in very inefficient staffing and operation, but remodeling is impossible because seismic regulations prohibit moving weight bearing walls.
- The 1960 ambulatory clinic building sees over 100,000 visits per year in space designed for only half that number. It is inefficient, crowded, and outmoded in design. Patients wait in the corridors in large numbers and, for long periods.
- The intensive care units are completely out of code compliance, lack visual and auditory privacy for patients, and are located in a seismically inadequate structure. The sickest patients are seen in the most sub-standard setting.
- The emergency department, which will see 65,000 patients this year, is the busiest in the county and surrounding region. It has also been cited repeatedly by JCAH and the State licensing agency. Conditions in the emergency department are completely chaotic even on "routine" days.
- Almost all VMC buildings have been cited by the fire marshall over the past several years. The correction of cited conditions will exceed $2 million in cost. The fire marshall has made four site visits this year alone, each one increasingly serious.
- Psychiatric patients are housed in the oldest building at the hospital. The fire marshall and licensing agency have threatened to close the facility for five years, and have recently succeeded in closing half of it to patient care. The

effect of this will further reduce the hospital's revenues and prevent access to the only acute public psychiatric facility in the area.

- Even in the most modern building, typical patient wards are 60 beds in size. This results in inefficient staffing and increased costs of operation.
- Numerous deficiencies exist throughout the medical center in mechanical, electrical, air handling, security, fire protection, and communications systems.

VMC Capital Financing

When VMC began planning for capital replacement in 1977, the cost to replace the needed facilities was $82 million. Now, almost seven years later, the costs have escalated to over $200 million. VMC's inability to obtain capital financing has delayed the project several years and escalated its cost more than 150%.

VMC is in business - but it's bad business to take care of unsponsored and government sponsored patients. Medicaid, Medicare and unsponsored patients comprise 76% of VMC's revenues. Because of this mix, an annual operating loss is a virtual certainty. Since the hospital cannot ever meet its operating expenses, the prospect of financing any meaningful capital project is becoming increasingly remote. As it is, the County subsidizes VMC for its annual loss and is thus less able to assist in debt retirement.

VMC has been forced to scale down the project several times over the past few years to define an affordable project which still meets some of the needs. The currently proposed project - totalling $48 million - addresses only the most critically needed facilities and it is still not clear whether we can meet that debt capacity.

Something must be done. Capitalization can no longer be delayed. If VMC and other public hospitals continue to be excluded from capital markets, yet because of their mandated patient population continue to operate in the red, the public hospital system will not longer be viable.

In conclusion, I think it is clear that public hospitals require special recognition for the unique service role they plan in their communities. However, this special recognition must also be translated into specific measures to aid public hospitals in meeting their capital financing needs if they are to survive and continue their mission into the future.

I appreciate the opportunity to testify here today, and now I would be happy to respond to any questions or comments you may have.

IV. THE UNEVEN PLAYING FIELD: PUBLIC HOSPITAL CAPITAL NEEDS

This final part of my prepared testimony will be divided into three sections:

- General overview;
- Capital needs in California; and
- Recommendations to the committee.

A. General Overview

Most public hospitals are operating with deteriorating and outmoded plants. Their unique financial base presents, in most cases, insurmountable barriers to securing capital for necessary improvements and/or expansion.

Cost-effective service delivery by public hospitals, as highlighted above, has had its price. One of the major prices paid has been deterioration of the capital assets of most public institutions. Many now operate with inefficient physicial plants, outmoded equipment and, in some cases, almost a total lack of amenities.

According to Standard & Poor's, there is an inverse relationship between the proportion of hospital's revenue attributable to Medicare and Medicaid and its bond rating: those with less than 35.6% of their revenues coming from Medicare and Medicaid are more likely to have an AA-/AA rating, while those with 45% or more are likely to have a BBB/BBB+ rating. NAPH member hospitals receive an average of 39% of their revenues from Medicaid and Medicare. This percentage does not include unsponsored indigents, which in most cases outnumber Medicare and Medicaid patients.

Recent studies comparing the public hospital capital situation with other hospitals have clearly underscored the serious problems faced by many public hospitals in metropolitan areas.

For 1983, capital costs accounted for 7 percent of Medicare reimbursements to hospitals in general. Payments to public hospitals with over 400 beds averaged 3.9 percent. This payment level was the lowest by over 1% for any of the categories of hospitals reported by Anderson and Ginsberg (1983).

Public hospitals have also shared the lowest rate of increase in capital expenditures (5%) for a five-year period in the mid to late seventies, when compared to voluntary facilities (15.6%) and proprietary institutions (12.1%) (Kinney & Lefkowitz 1982). The author concludes that "apparently public hospitals are using a large proportion of their discretionary funds to cover operating deficits".

The excess of depreciation reimbursement over debt principal payments - $180 million or 2.9% of Medicare and Medicaid reimbursement for 1981 "suggests a paucity of capital investments in recent years" for public hospitals. By comparison, the average voluntary hospital's depreciation reimbursement - 2.3% - equalled its debt principal payments. (Kinney & Lefkowitz, 1982).

As Don Cahodes concludes in his 1982 report on hospital capital formation, "It is almost tautological that hospitals with a large dependence on Medicaid and a significant amount of bad debt will fare poorly in the capital market. . . . The higher the portion of Medicaid patients, the lower the bond rating." ". . . hospitals in the 1980's may be faced with the stark choices of turning away patients who cannot pay or entering into bankruptcy".

B. California Public Hospitals

While a preponderance of Medicare and Medicaid patients works to the detriment of hospitals in accessing capital markets, these problems pale beside the problems associated with the reliance of California's public hospitals on arbitrary, politically determined budget allocations in State support for the counties' mandated role in healthcare.

With Proposition 13 limits on utilization of general obligation bonds by the counties, public hospitals, like the non-profit private sector, must rely exclusively on revenue bonds to generate resources for needed capital improvements. Yet feasibility consultants who analyze the debt-carrying capacity of hospitals for use in bond issuance accord almost no value to State and country indigent care "subsidies". Because investment bankers look to projections of formula-driven revenues to assess a hospital's financial strength and place no reliance on the politically derived annual appropriations of State and local governments, public hospitals are almost entirely excluded from the traditional revenue bond market.

As reported by the California Hospital Association (CHA),

> "County hospitals have older facilities, and are currently investing in improvements at a lower rate than other hospitals, as shown in comparisons of the percent of value depreciated and capital investment rates.
>
> Age of Capital and Investment Rate
>
> | Ownership | Percent of Value Depreciated | Capital Investment per Square Foot |
> |---|---|---|
> | County | 41.9% | $1.46 |
> | Nonprofit | 35.9 | 2.43 |
> | City | 33.5 | 2.35 |
> | Church | 34.1 | 5.56 |
> | Investor Owned | 27.1 | 7.46 |
> | District | 29.4 | 10.69 |
> | Statewide | 34.0 | 3.82 |
>
> Measuring the age of county hospitals by dividing total depreciation by a single year's depreciation (which somewhat understates the actual age of the facilities), less than one-third of county hospital beds are less than 10 years old, compared to over 90% of other hospital beds. Over one-fourth of the county beds are over 20 years old, compared to less than 1% of other hospital beds. The CHA analysis also showed that county hospitals' capital expenditures as a percent of fixed assets and as a percent of operating expenses was less than half that of other hospitals."
>
> Source: CHA Insight, July 25, 1983.

CAPH data also present a bleak picture of declining investments in capital improvements in members institutions. CAPH hospitals undertook capital expenditures which represented only 5.7%, 5.5%, and 3.2% of the total value of their physcial plants in 1980-81, 81-82, and 82-83 respectively. The majority of these capital projects were devoted to updating their facilities in order to comply with life safety building codes and JCAH standards. These modest investments can best be understood in relation of similar data for the industry in general. CHFC data show average capital investments over physical plant values for all hospitals in 1981 and 1982 respectively to be 18.8% and 21.0%.

Another measure of capitalization is that a capital expenditures per patient day. On this scale, CAPH data indicate that county hospitals invested at a fraction of the rates of private, non-profit, investor-owned and district hospitals. In 1983, for example, County hospitals invested at a rate of $7.20 per patient day compared to an average investment rate for other hospitals of $45.29 per patient day. These data are depicted graphically in Figure 1.

The volume of unmet hospital capital needs is also quite impressive. As reported by CHA,

> "A joint survey by CHA and the County Supervisors Association of California in April (1983) found that counties project health system capital needs over the next decade at over $717 million, including about $571 million, or 79% to meet licensing, certification and safety needs; $134 million, or 19%, to expand to meet rising patient demand; and about $13 million, or 2% to improve patient care quality."

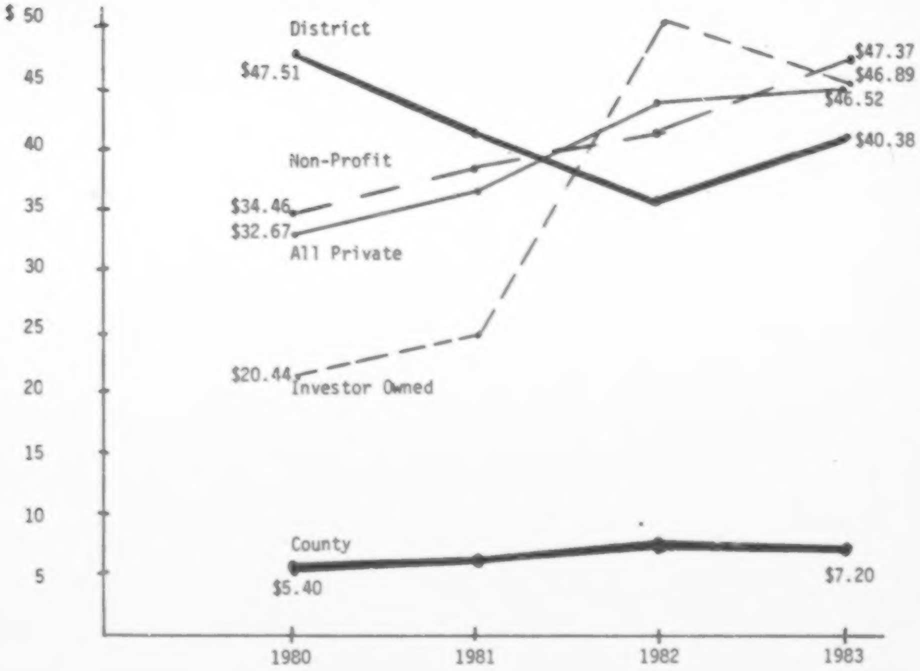
Clearly, special action will be required to address the unique public hospital capital dilema. Without special intercession there will be no way to ensure a legally and morally responsible level of care for the poor.

As a Johns-Hopkins Report on "Hospital Capital Formation in the 1980's" concludes,

> "Foreclosing their (hospitals serving the uninsured and underinsured patients) ability to access the capital market is tantamount to guaranteeing their future demise. The social service and community service function of hospitals serving the poor and the elderly should be valued and recognized by society and the government.

Figure I

CALIFORNIA HOSPITAL CAPITAL EXPENDITURES
Per Patient Day - By Hospital Type
1980 - 1983



Source: California Association of Public Hospitals

Note: Patient Days are for fiscal year 1980-81

C. Public Hospital Capital Needs: Observations, Recommendations and Conclusions

1. Public Hospital Access to Capital

The committee staff has asked us generally to discuss how public hospitals finance capital projects in our current health system. Without being unduly flippant, I think you will agree, on the basis of the information we've presented today, that we mostly do so poorly. While some metropolitan area public hospitals are more financially viable than others, this is often due to extremely unusual local situations.* On the whole, public hospitals today are far less able than many private institutions to generate capital internally or externally for needed construction, renovation, equipment, or maintenance. Several observations regarding public hospital access to traditional sources of capital financing may help to illustrate this concern. Those sources include philanthropy, equity, direct appropriation, and debt.

a. Philanthropy

With regard to philanthropy, there has been a relative decline across the board in capital project support from philanthropic sources - from 21% of all charitable contributions in 1968 to 5% in 1979. This overall decline severely limits this sector as a source of support for hospital capital projects in general. Moreover, this is an area in which most public hospitals have always been weak. Often, their viability is viewed locally as the responsibility of the taxpayer by those who usually donate money to construct wings or purchase equipment for hospitals.

---

* For example, there are several metropolitan areas in the nation (e.g., Minneapolis/St. Paul) where the overall incidence of poverty and uninsured patients is substantially lower than average. In a small handfull of other situations (e.g. Dallas County), a substantial and rapidly growing local tax base is more than sufficient to permit financing renovation of a hospital with a significant level of indigent care. But these are the rare exceptions among public hospitals in our metropolitan areas today.

b. Equity

In the classic sense of the term, equity financing is rarely available to public hospitals, for obvious reasons. While a certain amount of tax-motivated financing has been available in recent years to public hospitals, such as in the sale and leaseback of equipment, few public hospitals have used such financing. Legislation currently pending and likely to be enacted would significantly reduce its availability in any event.

While some public hospitals do occasionally manage to retain a small amount of revenues in capital accounts, which may be considered "equity", this is the exception rather than the rule. In any case such amounts are unavailable to fund any but the smallest capital projects. Indeed, with inadequate operating expenses exacerbated by large recent increases in uninsured patients, amounts set aside for even small capital purchases are often likely to be diverted to operating funds.

e. Governmental Appropriation

Some public hospitals continue to fund capital projects through direct governmental appropriations. But this source is rarely used for major projects in public hospitals today, except in areas where projects are (often inefficiently) planned to be funded over the course of many years. And in any case, we have seen a significant reduction in recent years in the willingness of State or local government entities to finance new projects. The significant reduction in state/local public hospital capital investment is born out in data gathered by the Government Finance Research Center and released only last week: State/local capital outlays for all structural projects decreased by 6.7% between 1981 and 1982 -- however, state and local outlays for hospitals decreased by 12% in that period.

d. Debt

By far the most important source of capital financing for most public hospitals today is debt. The problem is, this form of financing has also become the most important for all non-profit hospitals with capital projects -- a fact which can result in the crowding out of the often more fiscally distressed public institutions.

Many public hospitals once had available "general obligation" (GO) debt financing, by which the general taxing authority (the "full faith and credit") of a state or local jurisdiction would be pledged to obtain necessary credit.

However, this form of financing is now far less available for _any_ purpose, due to a variety of factors. In some states, taxpayer revolt has effectively closed down all GO funding. In others, once-fiscally-strong cities and counties are simply no longer able to command confidence or respect (and consequently an adequate rating) even for their GO obligations. And in still others, while there remains a willingness to use GO authority for some governmental functions (e,g. schools, transportation, prisons), hospitals often fall _outside_ that list -- perceived even by their governmental owners as enterprises which should pay for themselves to the extent possible from _revenues_.

Revenue bond financing is thus now the only major financing vehicle available to most public (as well as private non-profit) hospitals. Yet here, it is the very nature of the public hospital which makes capital difficult to obtain. As I have discussed above, bond rating agencies generally look first and foremost at a hospital's anticipated revenue stream in determining the hospital's ability to repay the bond. Yet they rarely give much credibility to _taxpayer_ revenues -- that is, the state or local appropriations or subsidy which finances uncompensated care -- as a source for repayment of debt.

Finally, public hospitals in general have been unable to take advantage of new or innovative tax exempt financing vehicles -- such as master indentures, certificates of participation, joint venture financing -- because of legal or political obstacles.

Given this bleak outlook, it is no small wonder that the response of many local governmental entities in recent years has been to sell or close their public hospitals, enter into long term leases or otherwise convert their hospitals to a nonprofit status. To the extent the entity which, by any of these methods, succeeds the public hospital continues to maintain an "open door" to the poor, perhaps little is lost as a result of such a transaction. Such a commitment does not always survive a transfer of ownership, however, and rarely survives the outright closure of a public institution. In such situations, particularly in urban areas, we may be creating a serious problem for all players in a local health system -- including those governmental and private insurers who would prefer to see a more highly price-competitive environment in our health care delivery system.

3. Recommendations and Conclusions

In conclusion, Mr. Chairman, I would like to offer several preliminary recommendations and conclusions regarding the capital needs of public hospitals.

a. "Level playing field"

First, I hope one thing should be abundantly clear from the data we have presented today: There is not, never has been, and never will be a "level playing field" in the hospital industry, insofar as public hospitals and their indigent patients are concerned. No private hospital that I am aware of has ever "competed" for the patronage of the non-paying patient. Unless or until we adopt a fair and rational national health plan in this country, the Congress and other key health decisionmakers must acknowledge and support the vital role of the present health safety net. Not to do so will prove disastrous for the rest of the hospital industry, as well as for public and private insurers.

b. Medicare Reimbursement

With regard to Medicare reimbursement for capital costs, we believe there is still much confusion about the appropriate role of Medicare (or any other health insurer) in funding the depreciation and debt service of health care facilities. We do not believe that simply "folding" capital payments into the DRG rate is going to resolve that confusion, however, or result in an equitable system in which genuine capital needs will be met.

True, many parts of our nation are overbuilt with hospitals and other health facilities today. And many hospitals continue to operate far less efficiently than others. But this does not mean that Medicare beneficiaries do not have a clear stake in ensuring the availability to them of adequate, needed, and carefully planned hospitals. Moreover, we also submit that Medicare -- as well as all other publicly and privately insured patients -- have a clear interest in assuring the continued availability of such facilities for uninsured patients as well. The marketplace alone cannot provide these assurances. This committee, therefore, must take into account the special capital needs of our nation's "safety net" hospitals in any Medicare or sytemwide capital initiative.

We recognize that the Congress clearly intended the DRG-based prospective payment system to produce "winners and losers" -- with more efficient hospitals obviously better able to live within prospectively set payment rates to cover operating costs. But we believe the concept of "winners and losers" has far less credibility in the area of capital finance. Simply increasing DRG payment rates by 7% across the board would provide no incentive to any institution to make (or be able better to afford) needed capital expenditures. Rather, some hospitals would simply receive unneeded windfalls, while others would see an effective end to any future hope of obtaining capital for needed renovation. Most public hospitals would clearly fall in this latter group. For while it is true that the average Medicare payment for capital is far lower for public hospitals than for others, this fact basically hides a tremendous potential need for future capital renovation and construction.

In other words, this situation exists because of a long history of deferred maintenance, spending capital funds to meet short term operational crises, and general inability to obtain capital financing. Solving these latter problems are frankly more important to most public hospitals than Medicare reimbursement principals -- but if we can solve the problem of capital *access*, we will need sufficient flexibility in the reimbursement system to pay our legitimate costs of future needed renovation and construction.

c. Assisting Public Hospitals to Obtain Access to Capital

We believe the Congress agrees with our assessment that, for the immediate future in any case, preservation of our nation's institutional health safety net is an important national goal. In the last three major health bills enacted into law, the Congress has acknowledged the need to give special consideration to "the needs of public or other hospitals that serve a significantly disproportionate number of patients who have low income . . ."

Despite the unfortunate refusal of this Administration to implement these provisions to date, we believe Congress agrees that the role we play is an important one. This acknowledgement must be carried over into the capital area as well -- not just through additional exceptions or exemptions from proposed new reimbursement policies, but in providing our nation's "safety net" institutions with *positive assistance* in obtaining needed capital as well.

We believe such assistance could take several forms. Given the length of this testimony, I would like simply to list briefly several possible approaches in concluding my testimony this morning. We would hope to be able to work with the committee over the next several months on some of these ideas or proposals.

- Credit enhancements, such as an expanded program of hospital mortgage guarantees, are increasingly important to hospitals serving uninsured patients. Last fall, the Congress adopted an NAPH sponsored amendment making FHA hospital mortgage insurance available to public hospitals for the first time. In the future, we believe a new and expanded program of loan guarantees may be essential to the viability of hospitals providing disproportionate amounts of care to the poor.
- Congress must insist that the Administration enforce and implement the clear Congressional mandate expressed in the 1983 amendments to provide exceptions or adjustments to the Medicare payment rate for hospitals serving the poor.
- Direct grants or loans may ultimately also be required for essential hospitals which cannot obtain needed capital any other way; and

- Greater flexibility in the tax code, possibly in the form of tax credits or exemptions from some of the restrictions currently under consideration, should be provided for taxable entities willing to enter into joint ventures (or otherwise work with) essential providers of care to the poor.

In conclusion, I think it is clear that public hospitals require special recognition for the unique service role they play in their communities. However, this special recognition must also be translated into specific measures to aid public hospitals in meeting their capiral financing needs if they are to survive and continue their mission into the future.

I appreciate the opportunity to testify here today, and now I would be happy to respond to any questions or comments you may have.

Senator **Durenberger**. Let me ask a general question of the panel. I have got the impression after a couple of hours of testimony that most of you, in one way or another—if you were able to give us some advice on where to spend our time—would tell us to concentrate our time on improving the financial access of everybody in this country to this health-care system that you are part of, rather than spending a whole lot of time on some of the kinds of subjects that we have been dealing with today—that, yes, there is an unlevel playing field to a degree out there because—if you are small rather than large or if you are downtown rather than in the suburbs or if you are—I could go through a variety of these—or if you are governmental as opposed to private—you are at some disadvantage.

What seems to be getting through to me is that what we really ought to be doing here is thinking about how we change from a system that reimburses institutions to a system that more adequately provides financial access to folks out there so that you can get the so-called marketplace back to competing on the basis of skills of the deliverer, or various deliverers of the services. Would anybody like to—or maybe all of you ought to—comment on that from the various perspectives.

Dr. **DuVal**. We not only concur wholeheartedly, Mr. Chairman, but as you know, in another setting we are advancing and have submitted to you a proposal for moving toward some variant of the health certificate or voucher to achieve that, and we honestly do believe that that is what you will end up pursuing some time in the future. It would probably take 3 years, but we believe that giving people purchasing power and letting them go the marketplace is the only reasonable answer to the dilemma we currently face.

Dr. **Weikel**. I might just add, however, that there are still going to be institutions that will have difficulty under that system because they are not going to be capable of competing—either because of quality of services, because of the quality of the facility, the fact that they are very aged, and people are not going to voluntarily want to go to some of those facilities.

So, it does not present an answer to all of the problems that we have out there, but it certainly is an approach that needs to be tried rather than a lot of the approaches we have undertaken.

Mr. **Bromberg**. To put it one other way, I think there is one source of capital we didn't mention this morning, and that is a legislative appropriation. I have always thought that public hospitals not only were different and not only had a higher burden because they were government as the witness said—the government is on the one side of the table and the government is also on the other side of the table—it is the only example of a government-run system—and yet we have always assumed that the legislatures would appropriate enough to keep that going. And that is where we have fallen down, and it seems to me that that is not really a capital issue at all. It is an issue of whether Federal, State, and local government are going to find the money to allow the public hospitals to continue to deliver that care, and the voucher approach may be correct for everyone else, but we may have to think of a block or massive-type voucher in terms of the disadvantaged.

Senator **Durenberger**. Before Bob responds to that, I would like to say that if we have fallen down on the legislative side it is because we have povertized the elderly in order to get them into the public hospital system and off the back of whoever else is in the system. If we did legislate all the things that needed to be done to put everybody on relatively equal footing, then maybe they could be making the choices. The problem then would be the one that Keith raises, which is how does the older hospital with this huge investment—how does it die, in effect, when somebody has a big investment in it—either in the Government field that owns it, or the private sector who has a big dollar investment in it. And still people aren't going there because if they have a choice, they would like to go someplace else.

Mr. **Sillen**. I basically agree with Dr. Weikel and Mr. Bromberg. I think, however, that this buzzword of competition and marketplace—to me they are sort of neutral words, not necessarily good, and not necessarily bad. And California, at this point in time, is probably the epitome of the competitive marketplace in health care. Most of the rest of the Nation doesn't even understand what is going on out there, and they can't believe it when they are told about it. I have trouble myself being there. But in any case, if competition and marketplace and market forces and segmenting the market and productivity and efficiency and bottom line is where we are going, then I don't care if it is a voucher or any other kind of system if the idea becomes to maximize profit or operating margin or bottom line—then that will be done. And if the voucher is going to be underfunded relative to other reimbursement sources—nongovernmental—the same choices will be made. So, I think that in the long run, it depends on how many horror stories develop over the next 3 or 4 years because we certainly haven't seen the worst of it yet in terms of health care. I think this entrepreneurial spirit and this competition in this marketplace is going to—within the next 2 or 3 years—produce the horror stories that make everybody hold their heads and say, "Oh, my god, what did we do?" For a large segment of the population—for the majority of Americans—it is going to be OK because the majority of Americans have access to whatever system there is. I am talking about that 20 or 25 percent who don't have it—now that is an awfully healthy percentage of the American people.

Senator **Durenberger**. I am inclined not to blame that on competition. I am going to blame that on the failure of the taxpayers of California or the legislators from California or the legislators that sit around here and can't figure out what has gone wrong with this system. And yes, now competition is showing us how we have screwed up—I mean the interprovider competition showing us how we have screwed up—and we are still sitting on our hands, saying, well, the answer to it is we just pay all the hospitals the same thing, and they will all survive and next year we will raise it all by 5 percent or 12 percent or something like that, and that is the answer to the problem. And I don't think that has much to do with quality of access or access to quality care.

Mr. **Sillen**. I wouldn't necessarily want to assign blame, of course, and it wouldn't be competition. Competition is to me, again, just sort of a word, but the way the process obviously works is that the Feds do it to the State, and the States do it to the local government, and the local government tells me to provide care to all people who aren't paying for it and to break even. Something is not going to work.

Senator **Durenberger**. I hope that you and Larry will get back here when we get farther into what we do about the economically disadvantaged, and certainly California is the place to learn it.

I have got to ask one last question, although I am being told that I am running out of time, and we have got to get Gary up here. We have not talked about medical education at all through this, and I wonder if—from each of your perspectives—you might have some comments about the impact, not only on capital but on the cost of medical education and what we are or aren't doing in our reimbursement systems to reflect that. Anybody want to start?

Mr. **Sillen**. Being a major teaching hospital, maybe I could give you one perspective, and I think that the teaching hospitals are different. The medical education issue for the public hospitals is really a significantly different issue than the way most people think about it.

If I do not have a faculty and if I do not have a house staff and residents, if I do not have a medical school affiliate, I do not have a medical staff because how am I going to get doctors to come in and take care of all those 21 percent uncompensated, and doctors don't want to take care of medical patients in the first place, and we are going to have increasing numbers of physicians who don't want to play in medicare, and that is my patient population. You know, so there is no financial incentive to come practice at my hospital. I need a full-time salaried staff which is what I have. The way I have been able to do that—the thing that attracts quality physicians to my institution—is quality teaching programs. It is really a significantly different phenomenon than just the teaching and is there a physician's glut, and so forth. It is survival for me and for many public hospitals.

Senator **Durenberger**. OK. Does anybody else want to comment on that issue?

Mr. **Bromberg**. I would just say that from the number of teaching hospitals that have started to talk to investor-owned hospital companies in the past 6 months to 1 year, that I would have to assume that the future capital needs of some of those older institutions are much higher than we may have anticipated, and that it may hopefully lead to some joint ventures and some innovations such as what has been done in Louisville, and many other different types of joint ventures now in Tennessee and Kansas City and Louisville and other places—under discussion—which leads me to believe that, again, it is not strictly a capital issue—although that is part of it with future capital costs facing those hospitals in the next decade—but again, it is going to get back to can you manage the costs?

One last point—earlier, you made a point about are we managing the indigent care load properly. There are a lot of aspects to that which are going to change under these new incentives. One of the largest teaching hospitals in America was managed for a couple of years by one of my members, and the first thing I was told was that they estimated that 60 percent of the charity cases in that hospital could be made medicaid eligible, and they put in a whole management team to do nothing for a whole year—I think it was something like one dozen or two dozen people—to sit there and fill out forms to put the people on medicaid, which didn't please the Governor or the Federal Government very much because that money came out of a different pocket. But there are ways to manage it, and I think maybe this crisis, in effect, is going to bring together a couple of sectors of the hospital field that were always considered separate.

Senator DURENBERGER. OK. Thank you all very much for your testimony.

Our last witness is Gary Capistrant, director of congressional policy, American Health Care Association, Washington, DC. Go right ahead.

STATEMENT OF GARY CAPISTRANT, DIRECTOR OF CONGRESSIONAL RELATIONS AND PUBLIC POLICY, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Mr. CAPISTRANT. Good morning, Mr. Chairman.

Senator DURENBERGER. Good morning, Gary. Thank you for being here.

Mr. CAPISTRANT. I am Gary Capistrant of the American Health Care Association. AHCA is the largest organization of nursing home providers. We represent 8,000 facilities across the country. With me today is Thomas Jazwiecki, who is also on staff.

We appreciate the opportunity to testify at what has basically been a hospital hearing, to add a little bit of perspective and different focus to your considerations.

One of our concerns is that usually when capital is considered, it is discussed in a way that is synonymous with hospitals, and we would like to make it clear that is not the case. Hospitals do have very expensive needs, and we have very expansive needs, when it comes to capital.

Another concern is that very often the decisions that are made regarding hospitals are imposed on other providers and that is seldom the productive policy. Also in the considerations there must be a recognition of other needs for capital in the health area so as to not disadvantage other types of providers.

And finally, we have had a great deal of experience with medicaid, which is the largest purchaser of nursing home services, and many of the medicare issues talked about this morning have been addressed, for better or worse, in the various State medicaid programs.

We would like to make two major points this morning, and one legislative recommendation. First, capital financing is the No. 1 issue for the future of long-term care. Just to keep pace with the booming elderly population, a new 120-bed nursing home would have to open each day. And that is not happening.

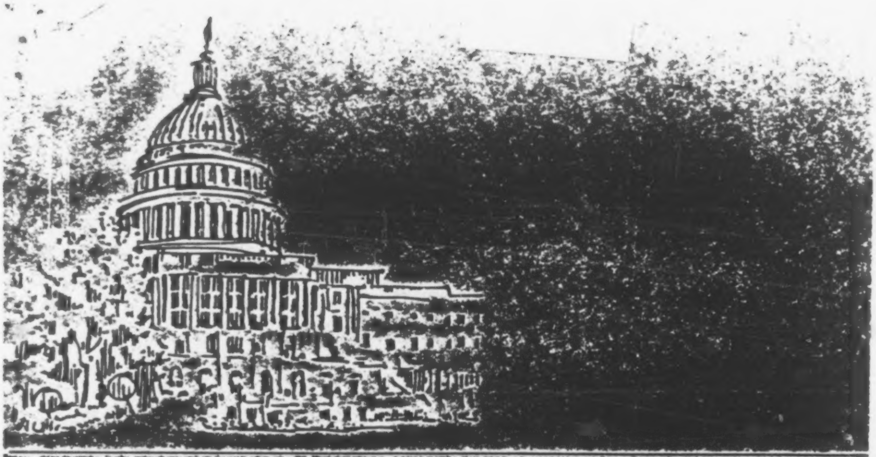
Second, there are major differences which must be recognized in capital financing objectives and opportunities between nursing homes and hospitals. The objective of capital policy for nursing homes must be to accommodate a rapid growth of beds in almost every locality. Waiting lists—not empty beds—are the problem of nursing home administrators. Also, the opportunities for capital financing are different and fewer for nursing homes. For example, much of the current nursing home construction is financed with small-issue industrial development bonds, whereas hospitals seldom use IDB's. Also, private capital is less attracted to nursing home investments, largely because of inadequate and unstable medicaid reimbursement and as I explained medicaid is the largest purchaser of nursing home care.

Some of the discussion this morning has focused on the importance of understanding differences in access to capital. Let me bring up, in that conjunction, that there is an enormous range of difference in nursing home facilities. Our membership goes from an 8-bed facility to an 800-facility provider. There are significant differences between and among provider groups in access to capital.

AHCA's top priority legislative recommendation—and important for this hearing—is something that Congress can do now on capital financing that would move us along. That would be to direct HHS to develop and implement during 1985 a medicare prospective payment plan for nursing homes. A prospective rate should recognize capital needs, thus giving providers the incentive to make the most prudent capital decisions and to eliminate Federal regulatory interference in the intricacies of capital financing. I appreciate the opportunity to present our views and welcome your questions.

Senator DURENBERGER. Thank you very much.

[Mr. Capistrant's prepared statement follows:]



Statement of the
American Health Care Association

Statement By

American Health Care Association

Before the

Subcommittee on Health
Committee on Finance
U.S. Senate

March [illegible]

ahca

American Health Care Association 1200 15th Street • Washington, D.C. 20005 • 202/833-[illegible]

For Futher Information Contact:

[illegible]

Mr. Chairman and Members of the Subcommittee:

My name is Gary Capistrant and I am Director of Congressional Relations and Public Policy for the American Health Care Association. AHCA is the largest organization of nursing home providers, representing 8000 facilities which care for 800,000 patients. Accompanying me is Tom Jazwiecki, AHCA's Director of Reimbursement and Financing.

Capital financing is the Number 1 issue for the future of nursing home and other long term care. All trends show the greatest population increase will be among those most in need of nursing home care. All other considerations, such as financing of services, are secondary to the availability of beds.

In recent years, hospitals have been the focus of capital financing discussions because of their more expensive needs; however, the impact of available capital is greater for nursing homes because of their more expansive needs. While similarities exist in capital financing issues between nursing homes and hospitals, they are not the same.

Expansion of services must be the objective of capital policy for nursing homes and other long term care, in sharp contrast to the hospital problems of downsizing and redistribution. Waiting lists, including patients "backed-up" in hospitals, is the challenge to today's nursing home, in contrast to excess beds in hospitals.

Also, nursing homes have fewer and different opportunities for capital financing than hospitals. First, the difference in scale between the costs of nursing home and hospital projects lead to different methods of financing. For example, nursing homes are heavy users of small-issue industrial development bonds, which have a $10 million per project limit, whereas hospital heavily use private activity bonds. Second, the investment community is less familiar with the operations and economics of nursing homes. For example, bond rating services have been reluctant to rate nursing home bonds and any ratings have been less favorable. Some of the private sector's reluctance is related to a third difference--nursing home viability is linked to Medicaid, whereas hospital viability is linked to Medicare and private insurance. Even with the recent changes to Medicare hospital reimbursement, Medicaid rates are less adequate and more unstable.

Current Legislative Issues

Several legislative issues within the jurisdiction of this Committee have important consequences for nursing home capital financing. The American Health Care Association recommends the following:

- Full Federal Medicaid funding be restored--Continuation of the reductions would be punitive since the states have reduced the growth of Medicaid funding much below Medicare growth and will continue to act more aggresively to contain costs for their own budgetary reasons.

- Medicare prospective payment for skilled nursing facilities be enacted—A prospective payment plan should incorporate capital costs, thus giving providers the incentive to make the most efficient capital decisions without regulatory interference.

- Industrial development bonds not be further restricted--Small-issue IDBs are an essential method of nursing home financing and result in lower capital costs to Medicare and Medicaid.

- A freeze on facility asset valuation should not be imposed--Recent reports on asset valuation should not trigger hasty and disruptive reactions. Nursing homes have experienced a variety of Medicaid limitations on capital cost accounting and a freeze is the most harmful.

It is estimated that an additional 1.2 million nursing home beds will be needed by the year 2000 just to maintain present age-specific levels of service. Dramatically stated, a 120-bed nursing home would need to open each day through the year 2000 just to meet that projected demand.

The potential capital investment in nursing home facilities will be significant. Currently, median nursing home construction costs approximate $25,000 per bed, although this figure varies by geographic region and type of construction. Using this cost approximation, it can be projected that future capital requirements--just to maintain the current level of nursing home services--will exceed $30 billion. If it can be assumed that approximately one-half million nursing home beds may also have to undergo renovation or replacement by the year 2000, the $30 billion estimate will be significantly higher.

There are several critical indicators which signal the enormous need for capital investment in the long term care industry:

- Demographic projections indicate an increasingly aged population and service need,

- New construction of nursing homes in recent years has not kept pace with the demand for long term care beds, and

- More than 70 percent of all nursing homes are 20 years of age or older.

The long term care population consists of persons who are functionally disabled as a result of a chronic illness or old age. The National Center for Health Statistics estimates that approximately 6 million persons who are substantially disabled represent the "hard core" of the long term care population. This group includes 3.6 million who need help with personal care or mobility and approximately 1.8 million living in long term care institutions.

The over 65 population will exceed 35 million by the turn of the century, according to recent projections by the Census Bureau. More significant is the rate of growth in the 75 and older age group--since this group is most likely to need nursing home services. The number of persons age 75-84 is expected to increase from 7.7 to 12.2 million with the 85 and over population more than doubling--from 2.2 to 5.1 million.

ELDERLY POPULATION ESTIMATE, 1980 - 2000

Annual Rate of Change					
Age Group	1980	1990	2000	1980-90	1990-2000
65-69	8,780.8	10,006.3	9,110.2	1.3%	-0.9%
70-74	6,796.7	8,048.0	8,582.8	1.7	0.6
75-79	4,792.6	6,223.7	7,242.2	2.6	1.5
80-84	2,934.2	4,060.1	4,964.6	3.3	2.0
85+	2,239.7	3,460.9	5,136.3	4.4	4.0
Total	25,544.1	31,799.1	35,036.1	2.2%	1.0%

SOURCE: U.S. Bureau of the Census, Population Estimates and Projections, Series P-25, No. 937, 1983.

These demographic projections alone have indicated that nursing home bed supply will have to increase approximately 3 percent per year just to maintain current proportionate bed to aged population ratios. But, bed supply growth is not keeping pace. GAO recently reported that during the latter half of the 1970's, nursing home bed supply grew at an estimated average annual rate of 2 percent, while the 85 and older population grew by 4.5 percent.

POTENTIAL DEMAND FOR NURSING HOME BEDS, 1980 - 2000

Elderly Residents:	Total Nursing Home Residents 1980	1990	2000
Age 65-74 @ 15 per 1,000	233.7	270.8	265.4
Age 75-84 @ 68 per 1,000	525.4	699.3	830.1
Age 85+ @ 216 per 1,000	242.8	747.6	1,109.4
Total Residents	1,242.8	1,717.7	2,204.9
Ratio of Elderly/Total Beds	.81	.81	.81
Nursing Home Beds Demanded	1,537.2	2,124.6	2,727.2
Increase over 1980	-	587.4	1,190.0
Average Annual Percent Change	-	3.3%	2.9%

SOURCE: John Valiante, Article to be published in Healthcare Financial Management, April, 1984.

The primary reasons for the lack of growth in the bed supply are twofold:

- Inadequate Medicare and Medicaid reimbursement levels make capital investment unattractive for a large segment of providers, and
- Artificial constraints have been placed on bed supply through health planning restrictions and certificate of need (CON) moratoriums.

Many states have taken advantage of the CON review to artificially restrict the supply of nursing home beds and thus control the states' Medicaid expenditures. Notably, about 10 states have imposed outright building moratoriums on new nursing home construction.

Methods of Capital Financing

National Center for Health Care Statistics data indicates that one-third of the existing nursing homes were built during 1953-1962. This period coincides with the expansion of the Federal Housing Administration Section 223 program and with the active use of both Veterans Administration and Small Business Administration loan guarantee programs. Of the 6300 facilities constructed during that period, about 10 percent were Hill-Burton assisted, the bulk of those being hospital-based facilities. Another one-sixth of the existing stock was constructed during the period 1963-1972. This group of approximately 3500 homes also benefited from the FHA program; however, toward the later part of the construction period (about 1969-1971) public stock offerings provided equity for expansion. Since 1973, the growth has slowed significantly, with fewer than 3000 new homes. Many facilities were upgraded to meet fire safety codes during that period of time (with some addition of beds), mostly with conventional financing. Since the late 1970's, most of the bed expansion has been done through debt financing, particularly tax-exempt bonds.

Today, the primary vehicles utilized by the nursing home industry for long term capital financing needs are the following:

- Conventional mortgage financing
- Industrial development bonds
- Public stock offerings (equity financing)

- Private capital investment through syndication

Each of these capital financing methods can be used singularly or in combination with others to afford a provider an efficient and effective source of capital funds. Each of these methods, however, is not without inherent difficulties. Conventional financing is relatively expensive when available and may not be fully reimbursable because of Medicaid capital reimbursement constraints. Industrial development bonds (IDBs) have become a major source of economical capital financing for nursing homes, but IDBs may be further restricted by congressional action. Curtailment of IDB financing will be a major setback for capital investment in the nursing home industry and will result in greater capital cost expenditures in the long run. Public stock offerings, while probably the most economical type of capital funding for major investments, are subject to timing and pricing factors characteristic of our equity markets. Considerable dilution of ownership without a corresponding economical source of capital funding can occur if stock prices are depressed when the equity offering is made.

Providers will seek out the most competitive and economically feasible capital financing arrangements when making long term capital investment decisions. Federal and state income tax considerations have a significant bearing on this decision making process. The primary concern, however, is whether the return on the capital investment is sufficient to warrant the financial commitment by a provider. In evaluating the return on a capital investment, the cost of capital in the decision making process will be weighed against alternative investment opportunities and the risks associated with such alternatives.

Evaluating the return on capital investment and the associated costs of capital is not done solely on the basis of a cost report line item reimbursement for capital costs. The decision is based largely upon the "bottom line," i.e., what the provider will receive for rendering the services. It makes little difference if Medicare or Medicaid singles out capital cost line items for reimbursement if the overall payment rate is insufficient to interest a provider to participate in the program. For this reason, Congress has an opportunity to address provider capital cost and program participation by nursing homes by urging the development of a prospective payment method for SNFs under Medicare that is both reasonable and adequate to guarantee beneficiary access to quality care. A fair and responsive prospective Medicare reimbursement rate would in itself address the capital financing issue, and do it simply without the need to involve government in the mechanics of capital funding or provider capital transactions.

Medicaid reimbursement, which is the primary source of funding for long term care services, is also an important reason for constrained growth in nursing home bed availability. Inadequate Medicaid payment levels and restrictive capital reimbursement policies have directly limited new construction and capital financing in several states.

Furthermore, the instability of Medicaid reimbursement plans deters most lenders and investors and results in higher program financing costs because of the perceived investment risk from those who do provide financing. Medicaid reimbursement rules change frequently to suit state fiscal and budgetary needs. In 1983, federal authorities received more than 100 state Medicaid reimbursement plan amendments to change payment methods for nursing home services. This type of program instability creates uncertainity in long [illegible] capital financing arrangements because lenders are apprehensive over the financial viability of extended debt amortization commitments.

Current Capital Reimbursement Under Medicare-Medicaid *Is Inadequate*

The current Medicare accounting method for recognizing capital costs, which has also been adopted by most state Medicaid reimbursement methodologies, creates long-run economic disincentives for nursing homes unless the facility is either sold or refinanced. To highlight: three major disincentives are associated with Medicare and most Medicaid capital reimbursement methodologies.

First, if a provider were to retain ownership of a facility over its entire estimated useful life, the total present value of all annual depreciation allowances would be less than one-half the value of the facility's original acquisition cost. This assumes annual inflation rates of 5 percent per year. If annual inflation rates were 10 percent, the total present value of the depreciation allowances received would be less than one-fourth of the facility's original acquisition cost.

Second, under conventional financing arrangements, Medicare-Medicaid depreciation allowances will, in the relatively short term, be insufficient to cover the principal payment portion of the debt service on the existing debt, thus creating a negative cash flow. This negative cash flow situation generally occurs in the seventh to tenth year of a conventionally financed mortgage, and presents a nursing home owner with three options:

- Continue under the present financial arrangement in spite of a increasingly negative cash flow;

- Refinance the facility under other, typically more costly, conventional financing arrangements; or

- Sell or restructure the operating entity.

Third, the values recognized for Medicare and Medicaid depreciation and return on equity purposes reflect only the historical cost basis of those nursing home beds. Yet, more than 70 percent of all of the existing nursing home beds are at least 20 years old. In some instances, these facilities may be almost fully depreciated which diminishes the value of any return on equity allowance. No recognition is given to the actual capital asset value in current dollars, even though inflation has increased approximately 10 percent annually over the last 10 years. Construction costs generally exceed inflation. As an example, between 1977 and 1982, the median construction costs for nursing homes increased approximately 80 percent. Providers owning facilities that were purchased or built during the 1960s and early 1970s have significant asset value appreciation reflected in their facilities. Since appreciation is not recognized, a provider can recognize the increase in his facility's asset value--the true worth of his investment--by selling the facility.

Because of federal budget concerns, proposals have emerged to further restrict the recognition of capital asset values upon the acquisition of a health care facility. Such a punitive response only exacerbates an already unfair reimbursement system for capital expenditures. Such "quick-fix" solutions, predicated upon short-term budgetary considerations, would have a catastrophic affect on the health care industry and would result in greater Medicare expenditures in the long run.

Several states Medicaid programs have attempted similar drastic measures to curtail the sale of health care facilities with the objective of controlling program expenditures. However, these attempts not only fail in this objective, but adversely affect private capital investment initiatives because they treat the symptoms of the problem, not the problem itself (i.e. inadequate funding levels). An example is the New York Medicaid program, which does not recognize any increase in provider asset valuation upon the sale of a nursing home. New York has had this restriction since 1977 and now faces a shortage of nursing home beds which has created a costly back-up of hospital patients awaiting nursing home placement. As a result, the private sector is reluctant to provide capital investment to build nursing homes in New York and today the state has one of the lowest rates of growth in nursing home beds.

I appreciate the opportunity to testify before you today and present the views of nursing home providers about capital financing and to share with you the impact of capital costs provisions under the state Medicaid programs.

Senator DURENBERGER. We hope on Tuesday to add to the reconciliation measure a requirement that HHS produce something like that you are talking about, not by 1985, but by December 1, 1984, so we can get it incorporated into the law.

Mr. CAPISTRANT. You know that we appreciate your efforts.

Senator DURENBERGER. OK. I take it some of the same things are happening in your field as are happening in the hospitals that we have heard from and that is that for a variety of reasons—one is cost of capital and another is the fair amount of multiownership developing. The old family owned nursing home is almost a thing of the past in a lot of areas, and you are subject to see many more multifacility ownership around this country. Is that accurate, and to what degree is this access to capital—or the cost of capital—part of a justification for that?

Mr. CAPISTRANT. Yes, Senator, there is active consolidation occurring among nursing home providers, not only by the large operations where most attention is focused, but also an increasing number of 5- to 30-facility operations. And the major reason for that consolidation does relate to capital financing. Tom can add to some of the reasons that that occurs.

Mr. JAZWIECKI. A lot of it, Senator, has to do with economies of scale, the ability to attract financing from the investor markets. We have heard here earlier testimony that size has a lot to do with it, but the key point is investors have a risk perception of the industry, and the less that risk perception, the more favorable the financing terms, and again, size having a lot to do with it. Risk perception is an interrelated concept. The better the ability you have to finance your operation, the better ability from an economical standpoint to pay back your debt service, and consequently the more favorable the lending terms you are going to get. In some cases the smaller operator may indeed have a larger perceived risk of operations, but a lot of that risk perception has to do with the unfavorable funding that the medicaid programs have adopted in most of your State programs today.

Senator DURENBERGER. I guess because interest rates in this country just won't go down, and everybody is afraid they are going up. But it is safe to conclude that the one thing that lenders like least is uncertainty in the market place, and I guess I hear your testimony—as I have heard previous testimony today—that we need to bring some certainty to the way we pay for both acute and long-term health care in this country, and that maybe once we bring that certainty to the day-to-day decisions that people are making about their sick care, their long-term care, then maybe a lot of this cost of capital business will take care of itself because we have a predictable long-term process for financial decisions. Is that basically your point in getting about the business of prospectives?

Mr. CAPISTRANT. Yes, it is. And again, the medicaid program is a very good example of that instability—not only the changes that come out of this room—but the changes that come out of the State legislatures, and through the executive agencies. In our testimony, we indicate that in 1983 there were over 100 State plan amendment changes under medicaid, just on nursing home reimbursement. Potential investors are deterred by such a level of program change as well as far-reaching discussions about the future of medicaid spending.

Mr. JAZWIECKI. I might emphasize, Mr. Chairman, that degree of instability in the medicaid program is not just a 1-year phenomenon. The 1983 figures that Gary cited are a representative reflection of the instability in the medicaid program. States continue to react to their own budgetary constraints by changing their reimbursement plans. In some States, the plan changes have been so frequent that there is very little fiscal stability in the medicaid program. This instability has only heightened the investor perception of risk in the industry. And that makes capital funding so much more difficult.

Senator DURENBERGER. Thank you for your testimony, and thanks for your willingness to be helpful to us during the course of this year.

The hearing is adjourned.

[Whereupon, at 12:18 p.m., the hearing was concluded.]

[By direction of the chairman, the following communications were made a part of the hearing record:]

Testimony of the
UNIVERSITY OF MICHIGAN HOSPITALS
Before the
UNITED STATES SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

Hearings on Capital Finances Under
the Medicare Program
March 9, 1984

The University of Michigan Hospitals ("UM Hospitals"), the oldest university-owned hospital in the nation, appreciates this opportunity to submit testimony on the issue of capital financing under the Medicare program. In announcing a series of hearings on this issue, Senator Durenberger noted that before Congress can decide whether and how the prospective payment system can be modified to cover capital costs, it must have an understanding of the current capital financing process, the roles played by the principals (including hospital management), the factors that they consider in making capital cost decisions, and the impact of these factors on their decision-making. The UM Hospitals believes that its recent and on-going experience with a $295 million capital replacement and improvement program will be instructive to the Subcommittee on these questions.

In the 1970s, UM Hospitals was faced with obsolete and inadequate medical facilities. In January, 1979, after an exhaustive study of plans for the replacement and renovation of selected components of UM Hospitals, a Replacement Hospital Program was adopted calling for $295 million in capital replacements and improvements. As this testimony will demonstrate, UM Hospitals successfully completed an extremely rigorous certificate of need review process, utilized the most cost-effective financing program available, and employed innovative and cost-saving construction techniques on a "fast-track" basis. In short, UM Hospitals managed the financing and construction of this complex capital project in the most economical fashion possible. The first phase of the Replacement Hospital Program is expected to come on line in early 1986.

In the comprehensive financial planning which preceded the Replacement Hospital Program, UM Hospitals, on the basis of then-prevailing Medicare regulations, expected Medicare to fund a significant share (approximately 26%) of the capital costs of the project. The possible inclusion of capital costs in the prospective payment system threatens to undermine the sound financial planning on which this project was predicated. UM Hospitals intends to submit oral and written testimony in future hearings on the capital cost issue which will demonstrate to Congress that the financial viability of even the most well-managed, critically needed, and cost-effective capital projects may be seriously threatened if Congress includes capital-related costs in prospective payment amounts without taking steps to protect UM Hospitals and others which are similarly situated.

Background of UM Hospitals

The UM Hospitals was founded in 1869 by the University of Michigan and was the first university-owned hospital in the nation. It is currently the only one in Michigan. The UM Hospitals serves the state as a major tertiary care referral center, offering every major specialty and sub-specialty in medical-surgical, psychiatric, and rehabilitative care for infants, children, and adults. The primary service area of the UM Hospitals, including 13 counties in Health Systems Areas I and II of Michigan, accounted for 72.8 percent of admissions in calendar year 1982. Its secondary service area, defined as the remainder of Michigan, accounted for 22.9 percent of 1982 admissions. The remaining 4.3 percent of admissions were from outside of the state. These admissions are in the care of the UM Hospitals medical staff which embraces 684 attending, courtesy, and honorary physicians of whom 443 are board certified in their respective specialties.

The UM Hospitals had 27,176 admissions and 271,145 patient days during fiscal year 1983. Its seven hospitals have 964 beds including 570 beds in the Adult Medical-Surgical Hospital, 208 beds in the C.S. Mott Children's Hospital, and the remainder located in the Adult Psychiatric Hospital, Children's Psychiatric Hospital, Women's Hospital, Holden Perinatal Hospital, and the W.K. Kellogg Eye Center. The UM Hospitals also received 30,496 emergency service visits and 378,777 ambulatory visits in its 132 specialty and sub-specialty clinics during fiscal year 1983.

The UM Hospitals employ a full-time equivalent staff of approximately 4,717. There are approximately 679 residents in graduate medical programs at the University as well as nearly 4,000 students in the Schools of Medicine, Nursing, Pharmacy, and Social Work.

Certificate of Need

In Michigan, a health facility must obtain a certificate of need ("CON") from the Michigan Department of Public Health for any capital project in excess of $150,000. Accordingly, the UM Hospitals' Replacement Hospital Program was subjected to a comprehensive and rigorous CON review. At each stage of the process, UM Hospitals was called upon to demonstrate that there was a compelling need for the replacement facilities. Having successfully met this challenge at each turn, the review culminated in the issuance of the requisite CONs.

In January 1979, with the approval of the Regents of the University of Michigan, the UM Hospitals filed a CON application for the Replacement Hospital Program. The application sought approval of a total of 893 beds at a projected cost of $244 million. Authority for an additional 29 beds for burn patients was sought in a separate CON application. The Program proposal included a construction project to provide modern facilities for those functions currently housed in the Adult Medical-Surgical Hospital, the Adult Psychiatric Hospital, and various ambulatory facilities. It also included renovations of five other medical facilities at UM Hospitals.

The need for the new and renovated medical facilities was clear and compelling. The Adult Medical-Surgical Hospital and the Adult Psychiatric Hospital are 59 and 45 years old respectively. They are obsolete and incapable of meeting the growing demands placed on a modern hospital. Regulatory bodies and accrediting agencies frequently cited these facilities for many serious inadequacies in the plumbing, ventilation, and sprinkler systems. In addition, the structural, mechanical, and utility systems are incapable of accepting many new and needed types of medical equipment. Stopgap remodeling and renovation measures proved to be extremely expensive -- UM Hospitals spent $3 to $5 million annually on such endeavors -- and inadequate to address the major problems which accrue from working in an obsolete facility.

The cramped and outmoded facilities generated additional problems including fragmentation of departments causing inefficient use of manpower and equipment and difficulties in attracting and retaining high-quality professional staff. Hospital census is also adversely affected because of declining patient acceptance of rooms ranging in size from 4 to 18 beds in the Adult Medical-Surgical Hospital; most other hospitals in Michigan offer private and semi-private rooms with private bath, telephone and air conditioning. The Department of Public Health agreed that there was a substantial need for the Replacement Hospital Program. After an exhaustive review at the regional and state levels, the Department issued three CONs totaling $295 million. Two CONs, totaling $10 million, were issued for the acquisition and renovation of the former St. Joseph Mercy Hospital (now the North Ingalls Building) and for the renovation of other existing UM Hospitals facilities. These projects enabled the UM Hospitals to move functions out of buildings that were to be demolished as a part of the site preparations for the new Program facilities. The Department issued a third certificate of need for the principal components of the Program with a maximum approved cost of $285 million.

The CONs contained several stipulations to ensure that the new and renovated facilities would be operated in a cost-effective manner: (1) the licensed capacity was reduced from 964 to 888 beds effective with the opening of the new facility; (2) the opening of a new patient unit of 32 beds was suspended until the UM Hospitals has achieved an average utilization rate of 91 percent over a year's period of time in the adult medical-surgical beds; (3) the number of operating rooms was limited to 30; (4) the minimum number of beds on a patient unit was set at 32; and (5) the University was to have use of the new Adult Medical-Surgical Hospital and the North Ingalls Building for non-patient care uses after they became operational.

The rigorous CON review process to which the Replacement Hospital Program was subjected coupled with the restrictions imposed in the CONs ensures that the Program was not a frivolous project undertaken for the purpose of meeting some illusory need or satisfying a whim or ego. It was instead a badly-needed project which, as will be shown below, was financed and constructed in a manner designed to achieve substantial cost savings.

Program Financing

The UM Hospitals, in conjunction with its investment banker, Salomon Bros., Inc., and its feasibility consultants, Touche Ross and Co., developed a plan for financing the Replacement Hospital Program which relied upon the following sources of funds:

State Building Authority Bond Proceeds	$140,000,000
State General Appropriations	33,000,000
Hospital Revenue Bond Proceeds (excluding a debt service reserve of $15.5 million)	102,000,000
University Capital Campaign	20,000,000
Total sources of funds	$295,000,000

The sources of these funds are described in detail below. A discussion of the uses of the funds is also set out in the section entitled "Program Construction".

(1) State Building Authority Bond Proceeds

The State of Michigan has long been committed to supporting financially the Replacement Hospital Program. In 1977, a State Building Authority was created to issue and sell bonds for the acquisition and construction of certain facilities including $140 million allocated to the new facilities for the UM Hospitals. To provide these proceeds for the construction of the new Adult General Hospital, the State Building Authority issued bonds with a 30-year maturity in December, 1982 at an average interest rate of approximately 11 percent.

The State Building Authority bond issue is secured by a pledge of rental payments to be received from the State of Michigan pursuant to a lease agreement executed by the State Building Authority, the State of Michigan, and the University. Pursuant to the lease, the Regents of the University of Michigan, acting on behalf of the University, conveyed ownership of the Adult General Hospital to the State Building Authority which then leased such facilities to the State. During the 30-year term of the lease, the State is contractually obligated to make all lease payments to the trustee for the State Building Authority from the State's general fund appropriations. Debt service on these bonds will be paid by the trustee to the bondholders from such lease payments. The UM Hospitals is obligated to pay all operating and maintenance costs of the Adult General Hospital until the lease expires, at which time the State Building Authority has agreed to sell the facility to the University for one dollar.

The UM Hospitals was concerned not only with the rate at which funds for the Replacement Hospital Project were borrowed but also with the rate at which monies were invested during the construction period. To assure that such funds were aggressively invested, the UM Hospitals solicited bids from numerous investment banks for a portfolio of investments which maximized the return on funds invested, thereby further reducing project costs.

(2) State General Appropriations

State appropriations for the Replacement Hospital Program are expected to total $33 million. As of January 31, 1983, $15.7 million of this amount had been appropriated and received and $.7 million had been appropriated and recorded as a receivable. The UM Hospitals expects approval for the balance of these appropriations will be obtained in future sessions of the state legislature. The State appropriations to date cover planning and architectural costs for the Adult General Hospital.

(3) Hospital Revenue Bond Proceeds

The Replacement Hospital Program was also funded through a complex, three-phase financing program consisting of the issuance of two short-term, tax-exempt note offerings (Series A and B in June, 1981 and April, 1982, respectively) and a long-term, tax-exempt bond offering which refunded both note issues in May 1983. */ The proceeds of the note and bond issues were used to complete the financing of the Adult General Hospital and the Ambulatory Care Facility. All three offerings were issued by the Regents of the University of Michigan.

This phased financing strategy was developed and implemented as a means of minimizing the costs of the Replacement Hospital Program, particularly the interest expense associated with the project during the construction period. As highlighted below, all elements of UM Hospitals' debt program were managed aggressively, thereby enabling UM Hospitals to reduce the amount of debt ultimately issued to fund the Replacement Hospital Program.

In June of 1981 and again in April of 1982, interest rates for long-term hospital revenue bonds were at historically high levels. The issuance of short-term notes during these periods enabled the UM Hospitals to secure the funds necessary for construction while keeping the interest expense approximately 3.0 to 4.0

---

*/ $14,675,000, Series A, Hospital Revenue and Bond Anticipation Notes, priced to yield 9 3/4%; issued June 1981.

$45,325,000, Series B, Hospital Revenue and Bond Anticipation Notes, priced to yield 9 5/8% and 10%; issued April 1982.

$114,090,000, Series 1983, Hospital Revenue Bonds, issued May, 1983 with net interest cost of 9.88%.

percent below prevailing long-term rates, thereby substantially lowering the UM Hospitals' cost of capital. Furthermore, the phased approach permitted UM Hospitals to issue debt only when additional funds were needed and only when capital market conditions warranted.

Although both note issues were secured by hospital revenues, the Regents also pledged to issue bonds secured by student fees in the event such hospital revenues proved insufficient to pay the debt service on the notes. The advantages of developing this unique security structure were threefold: (1) both series of notes received investment ratings of "AA", (2) the Regents were able to issue the notes without a letter-of-credit or similar credit support from a banking institution, a security feature which generally is a capital market requirement for debt with a balloon maturity, and (3) there was no need to increase the note size to fund a debt service reserve fund equal to one year's debt service as is customary in the tax-exempt markets for securities backed by hospital revenues.

As a result of this structure, the UM Hospitals obtained lower interest rates, eliminated any letter-of-credit fees, and substantially reduced the amount of debt issued.

When capital market conditions improved and yields for hospital revenue bonds declined below double digits for the first time in several years, the UM Hospitals' finance team was reassembled quickly to complete the final phase of the financing in less than nine weeks. This swift action enabled the UM Hospitals to lock-in its 30-year $114,090,000 bond issue at a net interest cost of 9.88 percent, representing one of the most favorable interest levels available in the preceding four years. In fact, interest rates for long-term bonds have yet to return to such attractive levels since the Series 1983 Bonds were issued.

The Series 1983 Bonds were secured solely by the revenues of the hospital. A feasibility study completed by Touche Ross indicated the demand for the UM Hospitals' services was high and that the institution would be capable of covering operating expenses, working capital, and its debt service requirements by an impressive 3.62 times and 4.0 times in the two fiscal years following completion of the Replacement Hospital Program.

Despite this outstanding coverage, certain factors beyond the control of UM Hospitals contributed to the bonds receiving disappointing "single-A" ratings (A-1 by Moody's Investment Services and A+ by Standard & Poor's Corporation) rather than the anticipated "AA" rating. Although the UM Hospitals' performance exceeded the results of comparable university-related institutions, the depressed Michigan economy, high state unemployment and reliance on tenuous state finances and appropriations were weighed heavily by the rating agencies. This lower rating is estimated to have added .25 to .5 percent to the interest rate on the outstanding balance over the 30-year term of the bonds and thus cost $6-12 million in incremental interest costs over the term of the bonds. */

---

*/ It is interesting to note that upon learning of the results of the first year under Michigan Medicaid payment reductions for the fiscal year ended 1983, Moody's Investment Service placed 13 Michigan hospitals with outstanding bond issues on its credit watch which now makes new debt issues difficult and expensive. The UM Hospitals was not placed on the credit watch.

The UM Hospitals also developed an aggressive program for the reinvestment of the note and bond proceeds similar to the program developed for the State Building Authority. This strategy maximized the income earned on monies invested during the construction period and thereby further reduced the amount of debt issued.

(4) Capital Campaign

The UM Hospitals intends to raise $20 million over three fiscal years with the pledges and gifts to be realized over a 10-year period. The campaign seeks $15 million in major gifts, $3 million from Medical School faculty/staff/alumni, and $2 million from hospital constituencies. As of December 31, 1983, the campaign had pledges and/or gifts totaling $2.8 million. Although campaigns are difficult to mount, especially against a trend of substantial decline in philanthropy to hospitals, its success is critical to the initiation of the renovations of several existing hospital facilities that will follow the completion of the Adult General Hospital and the Ambulatory Care Facility.

Program Construction

In the construction, equipping, furnishing, and financing of the components of the Replacement Hospital Program, the uses of the $295 million in funds are:

North Ingalls Building Acquisition and Renovations	$ 10,754,000
Adult General Hospital Construction and Equipment	202,989,000
Ambulatory Care Facility Construction and Equipment	35,820,000
Renovations and Equipping of Other Hospital Facilities	24,500,000

Activation of New Facilities	3,000,000
Financing and Related Costs	17,937,000
TOTAL USES OF FUNDS	$295,000,000

Management services in the construction of the Adult General Hospital and the Ambulatory Care Facility have been provided by Barton Mallow, C/M, Inc. All construction contracts are between the UM Hospitals and the various construction contractors and are fixed-price, lump-sum agreements. While the contractor bears the risk of unforeseen events affecting price, the UM Hospitals bears the risk of failure to maintain the construction schedule.

Construction of the Adult General Hospital commenced in October, 1981 on a "fast-track" basis whereby construction components are prepared in various bid packages which are submitted to contractors for solicitations of bids prior to the completion of the construction documents for the remaining Adult General Hospital components. Under this arrangement, each contractor has a guaranteed maximum price rather than a single such price with a general contractor for the total building construction. This approach is designed to achieve certain advantages, including the acceleration of the release of the individual bid packages in the market for contracting purposes under the "fast-track" approach; the savings realized by the UM Hospitals in a good "contractor bid" market; and the implementation of elaborate controls by the UM Hospitals management on the design and construction process in order to assure schedule and construction budget compliance. This contracting approach has been very successful. The accepted bids are $19.7 million under the $172.8 million in construction contracts issued through January 31, 1984.

Construction of the Ambulatory Care Facility at an estimated cost of $35.8 million began in June, 1983, also on a fast-track basis. The accepted bids were $1.2 million under the $23.0 million in construction contracts issued through January 31, 1984.

As part of the Program, the UM Hospitals is planning to renovate the Women's Hospital, the C.S. Mott Children's Hospital, the North Ambulatory Care Building, the Children's Psychiatric Hospital and the South Ambulatory Care Building. The UM Hospitals expects the renovation of these facilities to be completed by 1989 at an aggregate cost of $24,500,000. These facilities will be renovated using traditional and/or fast-track construction methods depending on the renovation components. The UM Hospitals has not yet awarded any contracts for the design or renovation of these facilities.

Conclusion

As the foregoing testimony evidences, the UM Hospitals aggressively developed and managed every aspect of the Replacement Hospital Program to make it as cost-effective and productive as possible, including:

(1) completing exhaustive planning studies to identify and define only those needs and requirements essential to continuing the delivery of the quality and diversity of health care services demanded of a university medical center;

(2) negotiating a significant $140 million contribution from the State of Michigan, the proceeds of which otherwise could only have been generated through the issuance of additional bonds by the UM Hospitals;

(3) instituting an ambitious three-year capital campaign to raise $20 million in contributions for the project;

(4) developing and implementing a multi-phase financing program designed to minimize the cost of capital and the amount of debt issued; and

(5) adopting and closely monitoring a fast-track construction management approach to the construction of the project, thereby substantially reducing the cost of construction.

The UM Hospitals again expresses its appreciation for the opportunity to submit this statement to the Subcommittee on Health and looks forward to future opportunities to make presentations to the Subcommittee relative to the impact of changes in Medicare capital financing on our Replacement Hospital Program. The UM Hospitals has worked diligently to bring the Program successfully and economically to its current posture and is now seeking to ensure that its endeavors, such as the Replacement Hospital Program, are equitably treated if capital-related costs are included in prospective payment amounts.

Testimony of the
UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS
Before the
UNITED STATES SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

Hearings on Capital Finances Under
the Medicare Program
March 9, 1984

The University of Minnesota Hospitals & Clinics (UMH&C), appreciates this opportunity to submit testimony on the issue of capital financing under the Medicare program. In announcing a series of hearings on this issue, Senator Durenburger noted that before Congress can decide whether and how the prospective payment system can be modified to cover capital costs, it must have an understanding of the current capital financing process, the roles played by the principals (including hospital management), the factors that they consider in making capital cost decisions, and the impact of these factors on their decision-making. The UMH&C believes that its recent and on-going experience with a $233 million capital replacement and improvement program will be instructive to the Subcommittee on these questions.

In the 1970s, UMH&C was faced with obsolete, inadequate, and substandard medical facilities. In April 1980, after exhaustive study of plans for the replacement and renovation of selected components of UMH&C, a replacement hospital program was adopted calling for $233 million in capital replacements and improvements. As this testimony will demonstrate, UMH&C successfully completed an extremely rigorous certificate of need review process, introduced, and secured passage of a legislative bill authorizing bonding authority for the State of Minnesota to issue $190,000,000 in State General Obligation Bonds for the project, and employed innovative and cost-saving construction techniques on a "fast track" basis. In short, UMH&C managed the financing and construction of this complex capital project in the most economical fashion possible. The first phase of the replacement hospital program is expected to come on line in mid 1984 with the majority of the program expected to be in operation in early 1986.

In the comprehensive financial planning which preceded the replacement hospital program, UMH&C expected Medicare to fund a significant share of the capital costs of the project. The possible inclusion of capital costs in the prospective payment system threatens to undermine the sound financial planning on which this project was predicated. UMH&C intends to submit oral and written testimony in future hearings on the capital cost issue which will demonstrate to Congress that the financial viability of even the most well-managed, critically needed, and cost-effective capital projects may be seriously threatened if Congress includes capital-related costs in prospective payment amounts without taking steps to protect UMH&C and others which are similarly situated.

Background of UMH&C

The University of Minnesota Hospitals was founded in 1911. State enabling legislation in 1921 established its early mission and financial base. The original mission was to provide care to those patients unable to afford care elsewhere and to provide a site for clinical education and scientific research.

Over the years, this initial mission of service, education, and research has continued to guide the development of University Hospitals and Clinics. While changes in the health system have reduced the need for a hospital to serve the state's disadvantaged, other changes have required the University to develop a broad range of health services including complex, highly sophisticated tertiary care. Likewise, the educational and research missions of the University have evolved from limited programs for medical student education and clinical research to broad ranging support activities in all aspects of Health Sciences education and research.

Today, University Hospitals and Clinics serves as the core support facility for Health Sciences activity at the University. While all clinical education and research activity does not occur at University Hospitals, the Hospitals provide a focal point for the initiation of clinical training, the development and maintenance of graduate educational programs, and the testing of new research models and service protocols. It is the proximity of researchers, academicians and practitioners within the Health Sciences Center which provides the impetus for new developments and has permitted the University to attain its acknowledged leadership role in Health Sciences.

The primary service area of UMH&C includes the 7 county metropolitian area of Minneapolis and St. Paul Minnesota. In fiscal year 1983, this area accounted for 41.9 percent of admissions to UMH&C. Its secondary service area, defined as the remainder of Minnesota, accounted for 34.6 percent of 1983 admissions. The remaining 23.5 percent of admissions were from outside of the state. These admissions are in the care of the UMH&C medical staff which embraces 559 attending, courtesy, and honorary physicians of whom 482 are board certified in their respective specialties.

The UMH&C had 21,055 admissions and 198,965 patient days during fiscal year 1983. UMH&C has 735 beds including 40 in Physical Medicine and Rehabilitation, 60 Psychiatric beds, 122 Pediatric beds, 8 Clinical Research beds, 11 Special Epilepsy Center beds and 494 Adult Medical/Surgical beds. The UMH&C also received 15,992 emergency service visits and 194,068 ambulatory visits in its specialty and sub-specialty clinics during fiscal year 1983.

The UMH&C employ a full time equivalent staff of approximately 3,640 as a part of an operation that had total operating expenses of $150.3 million in fiscal year 1983.

There are approximately 1,100 residents in graduate medical programs at the University and its affiliated hospitals as well as nearly 5,300 students in the Health Sciences.

Certificate of Need

The UMH&C replacement hospital program was subjected to a comprehensive and rigorous certificate of need ("CON") review. At each stage of the process, UMH&C was called upon to demonstrate that there was a compelling need for the replacement facilities. Having successfully met this challenge at each turn, the review culminated in the issuance of the requisite CON.

In Minnesota, a health facility must obtain a CON from the Minnesota Department of Health for any capital project in excess of $150,000. In August 1980, with the approval of the Regents of the University of Minnesota, UMH&C filed a CON application for the replacement hospital program. The application sought approval of a total of 737 beds at a projected cost of $233 million. The program proposal included a construction project to provide modern facilities for those functions currently housed in the Mayo Memorial Hospital, the Variety Club Heart Hospital, The Childrens Rehabilitation Center and the Boynton Health Service. It also included renovations of vacated space to enhance functions which now remain in these facilities.

The need for the new and renovated medical facilities was clear and compelling.

The majority of the beds available for patient use were in facilities that were built in 1911, 1918, and 1954. These beds are obsolete and incapable of meeting the growing demands placed on a modern hospital. Regulatory bodies and accrediting agencies frequently cited these facilities for many serious inadequacies in the plumbing, ventilation, and sprinkler systems. In addition, the structural, mechanical, and utility systems are incapable of accepting many new and needed types of medical equipment. Stopgap remodeling and renovation measures proved to be extremenly expensive -- UMH&C spent $2 million to $3 million annually on projects specifically related to these types of issues.

The cramped and outmoded facilities generated additional problems including fragmentation of departments causing inefficient use of manpower and equipment and difficulties in attracting and retaining high-quality professional staff. Hospital census is also adversely affected because of declining patient acceptance of the ward bed rooms without private bath facilities; most other hospitals in Minnesota offer private and semi-private rooms with private bath, telephone and air conditioning. The Department of Health agreed that there was a substantial need for the replacement hospital program. After an exhaustive review at the regional and state levels, the Department issued the CON for $233 million in capital construction and equipment.

The CON contained several stipulations to ensure that the new and renovated facilities would be operated in a cost-effective manner: (1) the licensed capacity was reduced from 898 to 719 beds effective with the opening of the new facility; (2) the active number of beds to be put in use was to be set at Health Board guidelines for occupancy, i.e., 70% for Obstetrics, 70% for Pediatrics, 90% for Psychiatric and 85% for Adult Medical/Surgical beds; (3) the number of operating rooms was limited to 18; and (4) the minimum number of beds on a patient unit was pegged at 26.

The rigorous CON and Legislative review process to which the replacement hospital program was subjected coupled with the restrictions imposed in the CON ensures that the program was not a frivolous project undertaken for the purpose of meeting some illusory need or satisfying a whim or ego. It was instead a badly-needed project which, as will be shown below, was financed and constructed in a manner designed to achieve substantial cost savings.

Program Financing

Although UMH&C introduced and secured passage of $190,000,000 in State of Minnesota General Obligation Bond authority, this avenue of financing proved to be unusable because of the problems with state budget deficits in 1981 and 1982. In order to keep the project on its fast track schedule and avoid escalating inflation on the project, the Regents of the University of Minnesota authorized a bond sale for the project in December of 1982. This authorization followed a downsizing of the new inpatient facility from $190,000,000 original cost to $125,000,000 and an extensive financial feasibility study by Touche Ross & Co. on the project. The Touche Ross Financial Feasibility Study was the third financial feasibility study performed on the project. Ernst & Whinney had prepared two financial feasibility studies on the larger project in times of lower interest rates assuming the use of State General Obligation Bonds.

During the period of downsizing, the firm of Lewin & Associates was used as a consultant to assure maximum efficiency in the operational aspects of the new building and to provide a third demand evaluation.

Anticipating increases in bond interest rates during 1983, the UMH&C sold a Hospital Revenue Bond Issue of $156,340,000 in December 1982, at an average interest rate of 9.9%. The proceeds of the Bond issue were utilized to complete the permanent financing of the new hospital and to provide for the planning of remodeling existing space in vacated facilities. The uses and sources of funds for this issue were:

	Amount
Use of Funds	
Note Refunding	$ 11,200,000
New Construction	115,180,000
Debt Service Reserve Fund	17,763,000
Capitalized Interest	49,993,000
Original Issue Discount	10,249,000
Financing and Related Costs	6,385,000
Hospital Prior Project Expenditures	1,329,000
	$212,099,000
Sources of Funds	
Bond Proceeds	$156,340,000
Earnings During Construction	28,687,000
Hospital Equity	25,829,000
Accrued Interest on Bonds	1,243,000
	$212,099,000

This bond issue was rated A-1 by Moody's Investment Service and AA- by Standard & Poor, based upon a feasibility study of the replacement hospital program by Touche Ross which forecasted the demand for the services of UMH&C and evaluated the ability of UMH&C to meet operating expenses, working capital, and long term debt service requirements during the six years ending June 30, 1988.

While the debt service coverage of UMH&C was good at 1.60 and 1.60 in the fiscal years ending June 30, 1987 and 1988 (the first full years after opening of the hospital), the rating agencies gave a A-1 and AA-, rather than the anticipated AA rating, because of the depressed Minnesota economy, high state unemployment, and tenuous state finances. This lower rating is estimated to have added ".25 to .5 of one percent" to the interest rate on the outstanding balance over the 30 year term of the bonds and thus cost $10 - $20 million in incremental interest costs over the term of the bonds.

Construction Management

The University of Minnesota and the Construction Manager entered into an Owner and Construction Manager Agreement, dated August 5, 1981, and an amendment dated October 28, 1982, as amended November 5, 1982 (collectively, the "Agreement"), pursuant to which construction management services will be provided to the University. The certified construction price for the construction of the project will be $92,691,791 (the "CCP"), which includes the Construction Manager's fee of $7,460,000. The substantial completion date for the project shall be no later than March 1, 1986 (the "Substantial Completion Date") and the completion date for the project shall be no later than December 1, 1986 (the "Certified Completion Date").

The Agreement provides that the Construction Manager is obligated to arrange for all labor, materials, equipment and services and to do all things necessary for the proper construction and completion of the project in accordance with the construction documents. The Construction Manager agrees to assume responsibility for completion of the project with the CCP and the Certified Completion Date except as otherwise provided in the Agreement. While there is no explicit provision for liquidated damages, the Construction Manager has agreed to reimburse the University for any costs which may be incurred by the University or loss of revenues incurred by the University resulting from incomplete construction on the Certified Completion Date.

UMH&C's renewal project is currently on time and running under budget by 15%. This result is due in part to the effective methods that have been used in planning the construction and the financing of this project. The inclusion of capital costs for buildings in prospective payment would severly undermine the efforts to date to make this an effective project.

UMH&C supports the position that the Health Care Financial Management Association (HFMA) has proposed, i.e., that movable equipment costs be included in the DRG rates but that capital costs for buildings and fixed equipment be paid on a cost pass through basis, for the following reasons:

A. If total capital costs are included in a prospectively determined payment rate based on historical national averages, hospitals such as the University of Minnesota who have recently undertaken large amounts of debt for capital renovation and replacement, would face significant cash shortfalls which would jepordize the repayment of principal and interest on these outstanding bonds. The cash shortfalls would occur because of the following reasons:

    1. Historically determined capital costs do not include an appropriate proportional share of the higher interest rates which are associated with recent bond issues nor do they include an appropriate proportional share of the higher construction costs associated with recent hospital capital construction.

       UMH&C has prepared several analyses with 7% and 9% capital percentage rates over 5 and 10 year phase-in periods. Each of these approaches leaves UMH&C from $1 million to $3.7 million per year in reduced reimbursements from Medicare payments alone.

2. Proponents of the American Hospital Association which supports total capital cost inclusion in the DRG rates argue that data requirements for separation of major moveable equipment and other capital costs do not exist. We believe that they do exist and can be identified both currently and historically to allow the development of a equipment percentage for DRG add-on within the prescribed congressional timetable.

B. We support the inclusion of the equipment costs in DRG rates because equipment purchasing is an annual reoccuring phenomenon which is planned and can be prioritized and decisions made based on economic factors. Where as major plant costs which occur once every thirty to fifty years and are secured through the issuance of debt, are costs which once made cannot be eliminated without severe consequence to the bond holder.

C. Feasibility studies which are required when bonds are issued also provide a mechanism to further analyze and review both the marketplace need and the financial structure's appropriateness before bonds for the new facilities can be issued. These studies are significant analytical approaches for evaluating the need and the financing capability for major plant expansion and/or replacement.

D. Price competition for services would be significantly distorted if an all inclusive rate were used as the basis for payment. Older facilities would profit through the averaging mechanism while newer, more expensive facilities would be penalized even to the extent of bond default. This could create several interesting phenomenons:

1. Sophisticated investors would no longer want to invest in hospital bonds due to the risk, unless the interest rate was high enough to balance the risk. This would then increase interest rates making the sale of bonds for new construction less affordable than at present. Higher interest rates means more cash outflow for interest expense which under a prospective price system reduces debt service coverage ratios which reduces credit ratings, which in turn increases interest rates.

   A highly likely outcome would be a gradual deteriation of our health care facilities because of the high risk of investing in hospital bonds.

2. For-profit organizations would have a significant advantage to purchase old and new facilities with equity capital. This would eventually lead to a significant reduction in non-profit hospitals and effectively take dollars from health care and distribute them to shareholders as profits.

3. Because federal programs would be paid using DRGs with average capital costs, a significant incentive would exist to care for these patients in average or less than average facilities. Those patients with more comprehensive insurance would be cared for in facilities they would pay for and we would revert back to the two class system of medicine that existed before the creation of Medicare and Medicaid. If a two class system of care did not evolve, it would be due to a significant cost shift from Medicare and other federal programs to other payors, again

not reducing the cost of health care but shifting it to those payors with more comprehensive benefits.

We believe that the HFMA approach avoids these senarios and is a more cost effective approach to managing health care costs.

UMH&C again expresses its appreciation for the opportunity to submit this statement to the Subcommittee on Health and looks forward to future opportunities to make presentations to the Subcommittee relative to the impact of changes in Medicare capital financing on our replacement hospital program. UMH&C has worked diligently to bring the program successfully and economically to its current posture and is now seeking to ensure that its endeavors, such as the replacement hospital program, are equitable treated if capital-related costs are included in prospective payments amounts.

If you have questions regarding this written testimony, please feel free to contact me at your convenience.

Respectfully,

Clifford P. Fearing

Clifford P. Fearing
Senior Associate Director and
Director of Finance
University of Minnesota Hospitals & Clinics
Mayo Building, Box 605
420 Delaware St. S.E.
Minneapolis, Minnesota 55455
(612) 373-8950

○